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**Cover:** Photo by our very own “White House Photographer” Fred Seligman, M.D.
MISSION STATEMENT
Mission of 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.
- Liases with other physicians and health care providers and collaborates with others who share common goals.

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In Response to the Horrific Tragedy in Newtown, CT: Our Response and Call to Action

Martin J. Drell, M.D.

While the details of the horrific tragedy in Newtown, Connecticut, still emerge, one thing is crystal clear: we can and must do better for our nation's children. Mental illnesses impact 20 percent of our nation's youth. Half of all lifetime cases of mental illness begin between the ages of 14 and 24. Yet, the majority of those diagnosed do not receive treatment. When left untreated, these disorders can lead to serious consequences for children, their families, and our communities.

In a speech announcing a task force on gun violence, President Obama said, “We need to work on making access to mental health care at least as easy as access to a gun.” We are not wasting time, we are taking the lead and urging the White House to convene a summit on children's mental health, with the goal of developing a comprehensive national strategy for the prevention, identification, treatment, and research of mental illnesses. By identifying children and youth struggling with mental illness and providing treatment, we can improve the lives of the next generation and avoid unnecessary tragedies.

This is no easy task. In recent years, state mental health budgets have seen the largest reductions since the 1960s. One in four parents finds it difficult to obtain mental health services for their child; struggling to obtain a specialist and to pay for the higher out-of-pocket costs. Waiting lists to see a mental health professional can be three months to a year long, and the wait can be even longer to see a pediatric specialist.

Mental illness is like any other disease. The earlier it is identified and treated, the better the outcomes. The longer we wait the more difficult and costly it is to treat. Effective treatments are available, but there are average delays of eight to 10 years between the onset of symptoms and intervention. Each year, mental, emotional, and behavioral disorders among youth cost $247 billion in mental health and health services, lost productivity, and crime.

We can avoid the tragic and costly consequences of unidentified and untreated mental illness in youth by taking action. We must invest in the prevention, early identification, and treatment of mental illness, rather than waiting until someone is in crisis to help them. We must increase access to services for children by ensuring there are enough mental health professionals to treat those in need. We must help schools and other child-serving systems provide and link children with effective mental health services and supports. And we must ensure that families understand signs of mental illness and how to access services.

As President Obama stated in his speech to the Newtown community, caring for our children is our nation’s first task. It is time to work together to make this a reality.

Martin J. Drell, M.D.
President, AACAP

AACAP Calls on the President for a Mental Health Summit

AACAP is urging the White House to convene a summit on children's mental health, with the goal of developing a comprehensive national strategy for the prevention, identification, treatment, and research of mental illnesses. We need your help in urging your Members of Congress to contact the Administration in support of this summit. Please visit www.aacap.org to send a prepared e-mail to your Members of Congress, see the letter to the President and a complete list of available resources.
Editor’s Note

Uma Rao, M.D.

Dear Members:

New Year’s greetings from AACAP News and its new editor! I am honored to serve as the editor of this publication that is widely read by the membership. I have served as the Annual Meeting section editor since 2006, first under the direction of William Bernet, M.D., and, then, Wun Jung Kim, M.D., M.P.H. During this tenure, I have observed the tremendous growth of the News under their leadership. Moreover, it has been a wonderful experience working with all the editorial board members. Therefore, when President Martin J. Drell, M.D., asked me to serve as the editor, I accepted instantly. Although it is not going to be easy to fill Bill or Wun Jung’s shoes, I hope I have absorbed some of their leadership qualities over the past years. I will do my best to continue their tradition of competent editorship and evolutionary development of the News. I am fortunate to have continued their input as well as the support from Rob Grant, managing editor; Patricia Jutz, production editor; and Editorial Board members and coordinators. Additionally, I very much look forward to suggestions from the Council and membership at-large. Since the News is meant for members across the spectrum, I strongly believe that its success depends on active involvement by all.

The News has a wonderful group of columnists, writers, poets, cartoonists, photographers, and other contributors on a wide range of issues and topics. I would like to continue this heritage while trying to bring about new ideas and changes. Here are a few ideas, some of which have been shaped by feedback from members.

- The News should be a voice of the diverse membership, representing academicians and private practitioners, clinicians and researchers, young and old, as well as various committees and caucuses.
- Showcase important contributions of AACAP, as well as its regional organizations and members, to improving the care of children and their families.
- Promote active debates on important topics in child and adolescent psychiatry.
- Educate members on relevant changes in healthcare, training, etc.
- Cover/develop new topics of interest to members (in response to member feedback), such as parent-child dyads in child psychiatry, translational science, etc.
- Invite our sister organizations across the globe to contribute to the News on relevant topics (e.g., their child mental health services, ethnic-cultural issues, etc.).
- The various categories of articles are summarized to assist members in contributing to the News.

The News section, edited by Ellen K. Heyneman, M.D., consists of articles written on behalf of an AACAP committee or regional organization. These pieces represent the views or activities of the component, not simply the opinions of the author of the article; and contributions from a component are limited to 3 or 4 times a year. While some committees have taken good advantage of this section to disseminate their work, over 80 percent of AACAP’s committees, the Assembly of Regional Organizations of Child and Adolescent Psychiatry (ROCAP), and regional organizations have not submitted any articles. We hope that this will change. Submissions do not have to be in the form of an article. We encourage committees and regional organizations to submit newsworthy items, such as their activity reports and announcements, in 250 words or less to be published in the Committee and ROCAP Corner.

The Components section, edited by Dunham, M.D., is the editor for the Columns section.

The Opinion section includes articles and letters to the editor written by an individual—usually an AACAP member, but not necessarily—about a topic of particular interest to him or her. Christopher K. Varley, M.D., is the editor of the Opinion section.

The Features section consists of material regularly submitted by AACAP members that do not fit into the other categories. This includes

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I hope you’ll join me in commending the AACAP Program Committee, staff, and leadership for hosting another amazing Annual Meeting in San Francisco. The science was incredible. Meeting child and adolescent psychiatrists and trainees doing amazing work all across the country was inspiring. The enthusiasm for our field and our work with children and families was palpable. If you are anything like me, your head was spinning on the way back from the Bay Area. There were countless new contacts with whom to connect. There were ideas for submissions for future meetings and projects within AACAP and back home. Most importantly, there was a renewed energy to reengage with my profession, my patients, and my community. As a trainee, this post-Annual Meeting period can be a useful time to make a plan to get the most out of not only the Annual Meeting, but your entire AACAP experience.

**Annual Meeting**

If you participated in the Annual Meeting Mentorship Program, get in touch with your mentor group! Your mentors will be interested in your Annual Meeting experience, and can continue to be a resource for you. You may see your fellow mentees on the interview trail or drop them a line to understand how their programs are tackling challenging issues. Most of us attended amazing educational sessions. Find a way to share new information and/or skills with your peers or even your local regional organization (ROCAP). If you met and exchanged contact information with leaders in the field, peers with similar interests, or AACAP leaders or staff, send them an e-mail (no, it’s not too late!). If you made plans to collaborate on a project with other attendees, now is the time to reach out to them. Strike while the iron is hot! (Or at least warm...) Hopefully, attending the Annual Meeting helped you develop ideas for even better programming for our next meeting in Orlando. Think about developing a Program Submission with a mentor from your program, or contacts you made at the Annual Meeting (due February 2013).

**Mentorship**

Some of the most consistent feedback we get from trainees at the Annual Meeting is the importance of mentorship. Beyond the Annual Meeting Mentorship Program, AACAP has also developed a Mentorship Network (www.aacap.org/cs/root/medical_students_and_residents/ find_a_mentor) that can connect you with a mentor in your area (or across the country) with similar interests. If you are a senior resident or child and adolescent psychiatry (CAP) fellow, consider signing up to become a mentor medical students or junior residents interested in child and adolescent psychiatry at your program. Consider meeting with your local Psychiatry Student Interest Group (PsychSIG), show them the new CAP-tivated video (www.becaptivated.org) and discuss career options in child and adolescent psychiatry. No PsychSIG at your medical center? Contact administrative or student leaders to see if you can help them start one!

**Most importantly, there was a renewed energy to reengage with my profession, my patients, and my community. As a trainee, this post-Annual Meeting period can be a useful time to make a plan to get the most out of not only the Annual Meeting, but your entire AACAP experience.**

**Committees**

Hopefully, you have had an opportunity to experience the work of an AACAP Committee. If not, look over the list of committees at the AACAP website (www.aacap.org/cs/members_only/ committees). Find several that interest you. Get in touch with committee chairs to see if there is a way to volunteer or “sit in” on calls (note: not all committees can accommodate this). If this is not possible with the specific committee you were interested in, look to see if there may be a related committee working in (or near) your area of interest. For those of you already on committees (or those that have successfully volunteered as above), talk with your committee chair about getting assigned to a committee project! Whether that is working on the next Annual Meeting submission, a fledgling Practice Parameter, an award selection process, or educational material development, getting involved in the work of a committee is the best way to “get your feet wet,” understand how AACAP works, and substantially contribute to the work of the Academy. For those not currently on a committee, keep in mind that applications for trainee members to committees will be due in July 2013 (www.aacap.org/cs/ root/medical_students_and_residents/ child_psychiatry_residents_fellows/ join_an_aacap_committee).

**Advocacy**

Now that we know that the Affordable Care Act and health care reform is likely “here to stay,” child and adolescent psychiatrists will be at the forefront of systems transformation across our country. Throughout the nation, decisions are being made about whether states will participate in federal Medicaid expansion plans, on how states will implement health insurance exchanges, on what mental health services will be covered under “Essential Health Benefits,” and on how “accountable care organizations” will be formed in your region. As trainees in child and adolescent psychiatry, we will be asked to interpret these changes for the children and families we serve. The ongoing Congressional financial negotiations may impact the
system of Graduate Medical Education funding through the federal Medicare program. Trainees can educate themselves about these and other legislative issues at AACAP’s Advocacy website (www.aacap.org/cs/advocacy/federal_and_state_initiatives). In short, this is a time when child and adolescent psychiatrists need to be increasingly involved in legislative advocacy. As Kristin Kroeger Ptakowski, AACAP’s director of Government Affairs & Clinical Practice says, “If you’re not at the table, you’re on the menu!”

Trainees interested in getting involved in advocacy – legislative, media, or community – can join the Trainee Advocate Program (TAP) (www.aacap.org/cs/residents_fellows/aacap_trainee_advocate_program). TAP provides information and planning support to engage in advocacy efforts in your community. Trainees have already been involved in educational outreach to local schools, advocacy training for local trainees, and legislative advocacy in our nation’s Capitol! You should also join AACAP for the 2013 Advocacy Day activities (www.aacap.org/cs/aacap_advocacy_day) on May 9-10, 2013! Children and families, trainees, and child and adolescent psychiatrists from across the country will join to learn about the latest legislative issues affecting children’s mental health and then fan out to the halls of Congress to speak directly with their legislators and staff. In the past, there has been limited funding for travel scholarships for trainees to attend Advocacy Day (applications were released in February).

Awards
AACAP has been increasingly successful in providing award opportunities to trainees, from travel grants for the Annual Meeting to summer programs to medical students to research awards for young investigators. Check the AACAP Awards website (http://www.aacap.org/cs/awards) for a comprehensive list. Applications for travel grants to the Annual Meeting are usually due in the preceding summer. Individual research awards have their own respective deadlines and application process.

Regional
If you have not yet done so, be sure to make contact with your local regional organization for child and adolescent psychiatry (ROCAP). ROCAPs are AACAP’s grassroots level organizations. Local members engage in continuing medical education, get legislative and organizational updates, and engage in regional advocacy efforts. ROCAPs are generally very open and interested in trainee involvement. See if there is a local project with which you can assist. Consider providing an update from the Annual Meeting. Or host a trainee-centric event to connect with senior members in your area for mentorship and career guidance.

Write
And lastly, we are always looking for guest columnists to contribute to the Wiener Resident Member of Council Column and the Mentorship Matters Column. Have an interesting training or mentorship experience you would be interested in sharing? Contact us! The Committee on Medical Students and Residents has also been working with the Journal of the American Academy of Child and Adolescent Psychiatry to develop trainee-oriented content (i.e., Resident’s Corner or Journal Club). If you are interested in helping developing this new initiative, please be in touch!

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 Jerry M. Wiener Resident Member to Council. He may be reached at sourav.sengupta@alumni.duke.edu.

Editor’s Note
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poetry, cartoons, and other art forms; and can include feature articles. Debbie R. Carter, M.D., is the editor of the Features section.

The Annual Meeting section, edited by Eva Szigethy, M.D., Ph.D., disseminates information not only about the Annual Meeting but also other meetings organized by AACAP. In particular, the January/February issue of the News provides highlights of the Annual Meeting.

If you are interested in contributing to AACAP News, or if you have comments and suggestions, please contact me. I may be reached at urao@mmc.edu. Also, please refer to the link on the AACAP website which provides instructions to the authors regarding the format, word limit, reference style, and timelines for submission: www.aacap.org/galleries/default-file/instructions_for_authors_201110.pdf.
The Hunger Games: What Fantasy Fiction May be Telling Us About Today’s Reality for Adolescents

I was in my 13-year-old daughter’s school library checking out some fantasy fiction books for her when the librarian commented, “Glad to see some kids are still reading fantasy fiction. Some parents won’t let their kids read it – too violent, too scary.”

I replied, “They obviously don’t understand the concept of displacement. It’s important for kids to have a vehicle they can use to feel and express unsafe feelings like aggression and sexuality, but, at the same time, keep them at a safe distance. Fantasy fiction allows kids to do that.”

Shortly thereafter, I sat in a small community theater watching The Hunger Games with my daughter. The movie is based on the first book of a trilogy by Suzanne Collins that is on many middle school curricula and summer reading lists, and which I had first heard about from a patient. The story takes place in 12 “districts” in which every year families must submit their children to a lottery. Those children who are chosen must participate in a ritualistic set of “games” that ultimately involve the youth, aged 12 to 18, being let loose into the woods, with the mandate that only one is permitted to come out alive. The survivor brings food and glory back to his or her district. The games are televised live. We witness desperately poor parents glued to the screen, egging on their children to prevent the family from going hungry and wealthy parents pressuring their youth to succeed and bring the family status and honor.

Many have commented that the book is more graphic than the movie. For example, David Denby in The New Yorker noted: “The filmmakers bait kids with a cruel idea, but they can’t risk being too intense or too graphic (the books are more explicit). After a while, we get the point: because children are the principal audience, the picture needs a PG-13 rating” (Denby 2012). So why could I barely watch – as healthy, and often lovely boys and girls, raced through the woods, killing each other in whatever way they could to stay alive?

“The poet enables us to enjoy our own daydreams without shame or guilt.”

—Sigmund Freud

Fantasy fiction in my day was the likes of the Narnia series, The Hobbit and The Lord of the Rings. The most terrifying scene from a childhood movie was the flying monkeys in The Wizard of Oz. As my kids grew up, I became familiar with and sometimes read their fantasy favorites. Harry Potter tops the list, of course. What a wonderful example of displacing childhood “daydreams” and fears – parental loss, magic powers, feelings of incompetence and competence, power, aggression, and, with the later books, sexuality. And while some episodes in the series certainly terrify (who was not terrified by the snakes in The Chamber of Secrets for example, or the Horcruxes or the Dementors?), a whole generation of readers came to experience the delight of their internal experience captured in the safe displacement of a world of wizardry.

In early middle school, my daughters embraced the Twilight series. I recall taking a van-load of 7th-grade girls to the first movie in that series with another mother. She and I sat in a row behind the girls and laughed while they watched agape. The love story between Bella and Edward, the handsome, pale young man who turns out to be a vampire, is loaded with the dangers of sexuality and aggression that are made safe by their displacement onto the world of vampires.

Why did The Hunger Games not feel safe for me in the same way? Clearly, its intended audience did not blink an eye. My 13-year-old watched it without so much as gasping or averting her eyes. A friend’s 13-year-old son told her that it wasn’t very scary because “There wasn’t any blood. …They don’t actually show them being killed.” Have youth exposed to violence like CSI on television or videogames like Call of Duty become desensitized to violence? Have they perfected their own defenses against it? Or am I simply a member of an older generation with a different spectrum of tolerable violence? Was I distracted by the manifest content and forgetting it was all “pretend”? I initially judged The Hunger Games to be the work of a “hack writer,” an example of taking a daydream (or nightmare – youth violence sanctioned by responsible adults!) and showing it “pretty much as is.”

Not long after I watched The Hunger Games, our outpatient director paged me from an early morning meeting. Two 9th graders at our local high school asked the outpatient director paged me from an early morning meeting. Two 9th graders at our local high school...
had been shot, one fatally, in a gang-related drive-by shooting while sitting on a stoop in a quiet neighborhood. It started to occur to me that perhaps our young people do experience their world as one in which adults, like in The Hunger Games, essentially sacrifice them. Gang-related violence occurs in the context of poverty, parents working multiple jobs, single-parent homes, and a lack of structured after-school activities for those who cannot afford them. As these stressors persist, perhaps youth do feel, consciously or unconsciously, that those who should be protecting them are instead submitting them up for sacrifice. I found myself thinking about the adolescent patient from whom I had first learned about The Hunger Games. She was the daughter of highly successful, perfectionistic parents who had imbued their child with such high standards and competitive drives that she was paralyzed with performance anxiety and unable to go to school. She had little sense of who she was beyond her grade point average and standardized test scores. Was she being sacrificed to her parents’ narcissism?

The dreadful thought occurred to me that perhaps The Hunger Games, while it seemed frighteningly “realistic” to me in its depiction of violence between youth in this sacrificial rite is, in fact, a displacement of our teenagers’ internal experience. Perhaps they love the books and the movie so much because they do capture and communicate adolescents’ sense of reality – a reality for some youth in which terrible things happen to them and the adults seem to just stand by; a reality in which adolescent is pitted against adolescent for the narcissistic glory of their parents. (We, as child and adolescent psychiatrists, may most identify with the character of Haymitch, the man who has the unhappy job of trying to help these adolescents navigate the pitfalls of the “games.”) As a colleague remarked, “It’s horrifying to think that children prefer a story about killing each other to addressing the reality of their modern life.” I am left with the conclusion that, in fact, The Hunger Games is not “hack fiction,” but rather a perfect, ego-syntonic displacement vehicle, one that leaves young people untouched and intact. But I, the parent and child psychiatrist, am horrified.

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Dr. DeJong is a former high-school English teacher and currently the associate training director for Child and Adolescent Psychiatry at Cambridge Health Alliance, and is in private practice in Needham, Massachusetts. She coordinates the Youth Culture column and welcomes your thoughts on this and any other column, as well as your topic ideas and submissions. She may be reached at sdejong@challiance.org.
SECLUSION AND RESTRAINT

Findings From the Last 10 Years: A Primer on How to Reduce the Use of Seclusion and Restraint

Kim J. Masters, M.D.

The AACAP Practice Parameter about seclusion and restraint prevention was published in 2002 (AACAP 2002). In the last decade, many programs have shown the ability to decrease the use of these interventions. Two recent reviews have selected factors common to many successful efforts (Gaskins et al. 2007; Scanlan 2010). The Practice Parameter contains a description of these elements (unpublished data), but not in a fashion that permits the evaluation of preventive strategies in programs that use these interventions. This article provides a template based on these review articles, for creating and assessing a seclusion and restraint reduction program.

Leadership: Assemble representatives from stakeholders, administration, staff, patients, families, and possibly, the public community. Commit to an ongoing process of decreasing seclusion and restraint use through data review, education, and training. While the target rate is zero for the use of restrictive interventions, initial goals can use existing national public rate 0.40 seclusions per 1,000 inpatient hours, 2.4% of patients secluded; and 0.45 hours of restraint per 1,000 inpatient hours and 5% of patients restrained (NASMHPD Research Institute 2012).

Review potential facility and literature factors that contribute to seclusion and restraint. Published articles could include the 2002 Practice Parameter, information from the NASMHPD website, articles about staff factors such as aggression and safety concerns (DeBenedictis et al. 2011), and patient factors such as previous aggression (Dos Rios et al. 2010), and the referenced reviews.

Select two training programs for the facility: a comprehensive collaborative approach that guides all treatment in the facility, and a separate de-escalation program.

Examples of a comprehensive program include: Trauma informed care, which sees seclusion and restraint deriving from and generating traumatic experiences (Hodas 2012, Huckshorn 2010) and Collaborative Problem Solving (Greene et al. 2006), teaching compromise as the core element in resolving patient staff conflicts.

De-escalation programs: Examples of these programs noted in the Practice Parameter include Crisis Prevention Institute, Non-violent Crisis Intervention, and Therapeutic Crisis Intervention. Other programs were reviewed in previous AACAP News columns (Masters 2004, 2005). Many of these programs also contain strategies for carrying out restraints or seclusion in a medically appropriate manner, if de-escalation fails or is not possible.

Training: Staff should be trained on both the comprehensive and the de-escalation programs. This education is part of learning collaboration skills to help children manage distress, anger, or fear using their own innate abilities supplemented by suggestions, dialog, and teaching conflict resolution skills. In this way, the staff helps the patient “to strengthen his/her own skills” rather than teaching how to follow institutional rules on “how to behave.” Language promoting self efficacy and adherence to personal goals should be encouraged, and replace directions emphasizing behaving and compliance.

Patient and Family Input

The welcoming of a patient to an inpatient or residential program has the following seclusion and restraint reduction elements:

- Assessment: including psychiatric diagnostic issues, trauma narratives, self-harm and aggression history, and environmental factors, especially family conflict triggers.

- Integration: including introducing the patient to the culture of the facility program, and developing a behavioral or safety plan to promote verbal de-escalation and conflict resolution strategies.

- Invitation: encouraging the family throughout treatment to provide suggestions to help the clinical program be responsive to their child’s cultural and social perspectives.

Medications

It is preferable to use medications to treat the primary psychiatric diagnoses, instead of Pro Re Nata (PRN) medications for aggression or crises. Current practice for PRN medications has expanded in the last decade to include oral and intramuscular second generation antipsychotic medication. For a review of emergency medication use, see Hilt et al. (2008).

Seclusion and Restraint

Center for Medicare and Medicaid Services (CMS) 1999 regulations permit the use of these procedures to prevent imminent self-harm and harm to others (CMS 2006). The 2006 regulations allow a trained registered nurse to review the restraint within the first hour, leaving a physician review to be completed within 24 hours.

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Debriefing

Two debriefing sessions are required after each seclusion or restraint: one with the patient, and one with the involved staff members (Huckshorn 2004; Joint Commission 2012). Both focus on preventing recurrence of these interventions.

How to Use This Information in Assessing Seclusion and Restraint Practices

Examine the structure of a seclusion and restraint program through a review of the manner in which information collected from individual components, e.g., leadership, training, etc., is shared and integrated. Then review individual debriefing events to determine how this information was applied to the individual patient’s treatment and the program’s management of restrictive interventions overall.

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Department of Health and Human Services CFR 482.13(e)(1)


NASMHPD (2012). National Public Rates. NRI. Falls Church, Virginia


Dr. Masters is Medical Director at Three Rivers Behavioral Health Services Midlands Campus Residential Treatment Center and Adjunct Professor in the Physician’s Assistant Program at the Medical University of South Carolina. He may be reached at kimjmasters@brontosaurus.org

Are You Ready for the New CPT Codes?

There are significant changes for CPT coding of psychiatric services that began January 1, 2013. AACAP has many resources designed specifically to help you the child and adolescent psychiatrist understand the changes and how they affect you. There are modules, webinars, and summary guides on how to use evaluation and management codes, how to use add-on codes, and other changes to the codes for 2013. Check out our resources available for you at www.aacap.org/cs/business_of_practice/reimbursement_for_practitioners.
AAPC’s Annual Advocacy Day
May 9-10, 2013

Join other AAPC members, and family and youth advocates May 9-10, 2013, to promote child and adolescent psychiatry and children’s mental health issues on Capitol Hill.

During this one and a half day event, you will join fellow members, residents, family members, and youth as you learn about the legislative process, develop relationships with legislators, and discuss the issues that most affect your patients and practice. The AAPC Department of Government Affairs will schedule your Congressional meetings, guide you on what to say and do during your meeting, and provide you with the policy materials to shape your message.

For more information, visit http://www.aacap.org/cs/aacap_advocacy_day or contact Emma Jellen at EJellen@aacap.org or 202.966.7300, ext. 128.
ECP Connect Program in New England—Launching and Sustaining a Career: Forging Connections Among Residents, Early, Mid-Career, and Senior Child and Adolescent Psychiatrists

Boris Lorberg, M.D., Yael Dvir, M.D., Georgina Garcia, M.D., and Sharon Weinstein, M.D.

Transition from training to practice is highly challenging for most child and adolescent psychiatrists (CAPs). Surveys of graduating CAPs suggest that, in spite of adequate clinical training, they report feeling not sufficiently ready for transition to practice. A national child and adolescent psychiatry survey of 392 early career psychiatrists (ECPs) found that many graduates felt unprepared for real world administration, leadership, medical economics, and business (Stubbe 2002). Surveys of ECPs attending AACAP Annual Meetings found that even those who are actively involved in the Annual Meeting program may have difficulty connecting with AACAP in their regions during the rest of the year. Many ECPs have expressed interest in meeting CAPs from their region who might provide advice about region-specific practice climate, job availability, and local AACAP programming.

In response, AACAP moved to support ECPs via the ECP Connect Program. AACAP awarded fifteen $2,000 grants to regional organizations of child and adolescent psychiatrists (ROCAPs) that applied and qualified. The New England Council of Child and Adolescent Psychiatry (NECCAP) ECP Committee implemented its grant by bringing CAP mentors and ECPs together in one regional forum to promote mentorship and networking, and to engage ECP members and to provide a developmentally appropriate setting for career planning (Horner et al. 2008; Martin 2005).

The NECCAP ECP Committee was initially formed by three ECPs: Boris Lorberg, M.D., Yael Dvir, M.D., and Georgina Garcia, M.D. Sharon Weinstein, M.D., NECCAP President and director of Continuing Medical Education served as a senior member and mentor to the group. The committee developed and distributed a ten-item, Internet-based, needs assessment survey and sent it using Survey Monkey to all NECCAP members, identified ECPs, and to local CAP training directors who distributed the survey to their trainees. The responses to the survey, as well as weekly committee conference calls over the course of a year, guided the development of the mentorship/networking conference described below. The target audience included CAP trainees, ECPs, as well as mid-career and senior CAPs.

The results of the pre-conference survey were reported in a new research poster presented at the AACAP 59th Annual Meeting in October 2012: ECP Connect Grant Implementation and Needs Assessment - Building Regional Mentorship and Networking in New England. (Lorberg et al. 2012). Of the 51 percent (41/80) of CAPs who responded to the survey, three-quarters indicated an interest in attending future mentoring and networking events. In response to a question about their current mentorship and networking needs, only five percent stated that their needs were completely met. Respondents indicated that they were most interested (in descending order) in peer supervision and mentorship network development, business administration, nuts and bolts of practice, time management, work/life balance, defining career, advocacy, and legal issues. A greater number felt very well-prepared to enter academic psychiatry than public or private sector practice.

The conference was held on May 19, 2012, and was designated by Massachusetts Psychiatric Society for four American Medical Association (AMA) Category I credits. Course co-directors were Drs. Lorberg and Weinstein. The conference began with private practice “pearls” presented by Bruce Black M.D., representing group practice, and Timothy Dugan, M.D., a solo private practitioner. Both stressed...
that professional gratification and the ability to form connections with patients, families, and other professionals were central in their job choice.

Dr. Black encouraged ECPs in the audience to ask themselves what sort of future practice they see for themselves, including what type of population they most enjoy working with, financial expectations, lifestyle, and level of autonomy. He discussed the “nuts and bolts” of starting a private practice, including pros and cons of group versus solo business models, pros and cons of managed-care participation, advice regarding intake, scheduling, electronic medical record-keeping, billing, liability protection, and clinical coverage.

Dr. Dugan presented another private practice model by describing his path to a home-based solo private practice, which allowed him to balance professional and family roles throughout the years. He emphasized the importance of forming connections with colleagues and community providers.

Donna Vanderpool, M.B.A., J.D., vice president at Professional Risk Management Service, Inc., offered up-to-date information about risk management in the electronic era. She discussed the challenges of social media, blogging, and online professional networking; and stressed that electronic Web-based material exists forever and is not, in fact, fully private. She presented vivid examples of physician violations of online professionalism and discussed disciplinary actions, along with the newly released policy of the Federation of State Medical Boards on the use of media in medical practice. Ms. Vanderpool also covered the unique challenges of an electronic medical record and the possible legal complexities that arise with the use of telepsychiatry.

A panel next discussed career paths in the public sector, hospital-based practice, research, academics/teaching, and schools. Mathieu Bermingham, M.D., represented CAP practice within the public sector and focused on how legal reforms in Massachusetts have set a national gold standard for family- and youth-centered treatment; Tony Jackson, M.D., presented his perspective as a hospital-based CAP. Paul Hammerness, M.D., described the rewards of being able to move between clinical care and research; Steve Schlozman, M.D., described his work and the opportunities within academics, teaching, and training; Nancy Rappaport, M.D., talked about the crucial roles for CAPs as school consultants; Tia Horner, M.D., gave an eye-opening talk about the challenges of balancing work and family life.

Dr. Weinstein, concluded the panel by summarizing the important role and contribution of regional and national professional organizations to CAPs at all developmental levels. She described ways in which regional organizations can serve as a “home base” for collegiality, continuing professional education and development, networking, mentorship, community education, and patient advocacy.

The program concluded with a stimulating question-and-answer session, moderated by Boris Lorberg, M.D., and Yael Dvir, M.D., followed by the opportunity to network with colleagues.

In the post-conference CME evaluation forms, completed by the 23 attendees (of 39 total attendees) who qualified for CME’s, the ratings of the overall activity were extremely high. On a 1 to 5 scale, with 1 as “poor” and 5 as “excellent”, 100 percent of respondents rated the program as a 4 or 5- with 74 percent (17/23) rating the program as excellent (5 on scale).

The evaluations also indicated almost unanimous agreement that the programs’ objectives were successfully met. Objectives listed were: 1) Identify basics of setting up a practice in an ethical, effective, and rewarding manner. 2) Recognize basic risk management strategies in child and adolescent psychiatry in an electronic era. 3) Discuss how to use regional mentorship and networking to improve the quality of clinical care and level of professional satisfaction. 4) Utilize the mentor/ECP relationships established in this activity. For questions 1 and 2, 100% of respondents indicated that the objectives were met. For questions 3 and 4, 96% (22/23) indicated that the objectives were met. The respondents felt overwhelmingly positive about the program.

This NECCAP program provided a lively forum for CAPs to connect, to network, and to exchange ideas about child psychiatry practice, research, and teaching.

Given the importance of mentorship to transition to practice, we present this program as a potential model for other regional councils, with the hope that this ongoing AACAP-ROCAP collaboration will inspire the development of future regional ECP initiatives.

References

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Acknowledgements
We gratefully acknowledge Joan Wall, NECCAP executive director, and Jennifer Neuwalder, M.D., conference reporter, for their invaluable assistance.
The Amazing “Shrinking” Academy

Marika Wrzosek, M.D.

The most amazing thing happened at this past Annual Meeting in San Francisco: AACAP – the Academy – had shrunk despite higher than ever number of members and Annual Meeting attendees. Before anyone re-crunches numbers, which again show growth by sheer member numbers, let me explain. There is a picture of 2-year-old me sitting atop a golden-brown, floppy-eared stuffed pooch. Dog, as he was called, lived in my memory as a gigantic presence protecting my overseas childhood bedroom from all sorts of “things that go bump in the night.” Plus, he made a phenomenal shield from my older brother’s suction dart assaults. In college, I saw Dog again in person – and he barely reached my knees. How did my faithful, childhood protector shrink so much?! While a silly memory, Dog illustrates the changing perspective that comes with age … and I would like to point out, not just age, but training and professional advancement.

Like Dog shrinking over the years, I have seen AACAP shrink – in a “this is because I’ve gotten bigger/older/wiser” kind of way. The first AACAP Annual Meeting I attended was during medical school, held in Boston that year. I remember thinking it was big and imposing, but with potential to offer a safety net for those lucky enough to engage it. There was something protective about AACAP; I saw that it afforded its members consistent encouragement and support, and many of the esteemed members that spoke exuded affection for the collegiality and camaraderie present at the Annual Meeting. I did not know it at the time, but AACAP also offered critical guidance and mentoring at all stages. I returned to the Annual Meeting during residency, through their Educational Outreach Program travel grant. As part of the award, I attended several mentorship events. Those events, such as the Medical Student and Resident Breakfast, the Mentorship Program, and the social events for trainees, proved to be instrumental in teaching me how to make the most of what AACAP offers. I realized that the world of child and adolescent psychiatry is both large and small – but by making connections across tables, oceans, and programs, it becomes the heart of a fairly small and manageable world of dedicated clinicians who want to take care of kids. Suddenly, it went from big and imposing organization to approachable and supportive.

This past October, I returned again as a first-year child and adolescent psychiatry fellow starting my two-year term as the John E. Schowalter, M.D. Resident Member of Council at the meeting’s conclusion. This year, I found myself mentoring young medical students in addition to being mentored myself, attending the many events sponsored by the Medical Student and Resident Committee and learning how to navigate a large organization and tap its plentiful resources. One of the things that AACAP has instilled in me during our relatively brief relationship has been that mentoring is an active process, and if you ask for it, it will happen. What allows AACAP to “shrink” yet never disappear is the network of support, guidance, and mentorship it provides? As we engage that network, the world gets smaller and less intimidating, and more warm and fuzzy.

Apparently what is a well-kept secret – or just a fact that residents ignore until Match Day – is that starting child and adolescent residency training is, at times, a regressive experience despite many instances of fun and glee that forces a resident to transition from being a competent general psychiatry senior resident to a confused first-year child psychiatry fellow. I have been told that these growing pains are temporary, permitting gradual achievement of mastery of certain diagnostic and treatment skills with training, and that you learn to both expect and tolerate a certain amount of uncertainty (it’s true – even a few months in, the growing pains are lessening). Navigating these growing pains would be impossible without help and encouragement of the class of fellows ahead of you and supervisors that let you know that it gets better and easier with time. And it would be impossible without the early career psychiatrists, just a few years out of
training, navigating their own transitions and growing into their own “adult” roles and “real” jobs.

During this past Annual Meeting, I had the pleasure of meeting child and adolescent psychiatrist Jane Caplan, M.D. Dr. Caplan was an alumna of my program, Massachusetts General Hospital/McLean Hospital. I was struck by two things: 1) she actually sought me out at a meeting with hundreds of attendees (I had met her husband at another conference, and he thought it would be good for us to connect), and 2) her recollection of growing pains and glee were similar to mine … and my guess is that it would be similar to many other fellows around the country. She understood what I loved about training, and she validated the myriad emotions and experiences I have logged since starting fellowship. Jane spoke of navigating change and weathering transitions, whether they were between or within institutions. She described her current position and career, and as I listened, I saw my perspective recalibrate. AACAP had facilitated yet another contact and, therefore, became just a smidge smaller. My network of trusted child and adolescent psychiatrists had grown by one more member who I felt truly understood what I was experiencing because she had done it a few years back in the same program.

I am grateful to Dog for protecting my bedroom, grateful to Jane for meeting and guiding me, and grateful to AACAP for the appropriately dosed, and always timely, support it has provided as I continue to navigate professional transitions. AACAP is no longer “SOOOO Big,” just “big.” And it is not so big that it is impersonal and stand-offish, but it is certainly big enough to offer me support, mentoring, and opportunities galore. So, thank you, AACAP – for shrinking to Goldilocks’ “just right.”

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Dr. Wrzosek is a graduate of the University of Illinois at Chicago College of Medicine, where she also completed her adult psychiatry residency training. She is now a first-year child and adolescent psychiatry fellow at Massachusetts General Hospital/McLean Hospital. Dr. Wrzosek is AACAP’s John E. Schowalter, M.D. Resident Member of Council and may be reached at marika.wrzosek@gmail.com.

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Attention Life Members!

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


AACAP Members qualify as Life Members when their age and membership years total 97. Please contact the Development Office at 202.966.7300 ext. 140 or development@aacap.org to find out if you qualify as a Life Member.
Despite Research, Parents Think Children Sipping Alcohol is a Good Idea

Prior research has shown a correlation between the age of first sip of alcohol and later risk for alcohol misuse. A substantial minority of children under 11 have tasted or sipped alcohol (with estimates ranging from 20-50%). Few young children report alcohol use outside of either a religious or family context. From previous literature, it is unclear whether early sipping by young children in a family context might be protective, harmful, or inconsequential for later alcohol misuse. Prior research has found that some parents purposefully give their young children alcohol to demystify its taste and to teach that moderation is the key to safe enjoyment of so-called “adult beverages.” A review of popular press suggests that parents more and more believe that children will not like the taste of alcohol if they try it, and will consider it less desirable if they are freely allowed to try it, leading to later decreased alcohol misuse.

Christine Jackson et al. at the University of North Carolina investigated these parental beliefs about alcohol and how they correlate with parent behaviors and children’s first reports of alcohol use. They conducted a large telephone interview study of 1,050 pairs of mothers and third-grade children as part of the initial phase of an ongoing intervention trial. Across a range of questions, the researchers found that about 20-40% of parents at least partially agree with ideas such as: letting children taste alcohol will make them less likely to want to taste it again, children who sip small amounts of alcohol at home will be less likely to experiment with risky drinking later, and that children will be more likely to view alcohol as a “forbidden fruit” if their parents never let them try any. The researchers found that the third-grade children of parents with these attitudes were much more likely to have sipped alcohol than their peers.

Popular trends among parents trying to protect their children from harm create quite the conundrum for the clinician when those trends contradict with research findings. There is attractive logic to the idea that parents can inoculate their children from problems with alcohol by modeling responsible behavior and allowing them to develop a healthy relationship with drinking from an early age. The problem is that our current research suggests this is likely the exact opposite of the truth, and child and adolescent psychiatrists and pediatricians are in a key position to debunk this myth with the families we treat, as many of these children have risk factors for problems with alcohol in the future.

archpedi.jamanetwork.com/article.aspx?articleid=1360891

More Bad News About Alcohol

The relationship between maternal alcohol consumption during pregnancy and adverse effects on their offspring has been the subject of numerous studies. There is clear and compelling evidence that excessive drinking is bad but what is the cutoff point? Most guidelines suggest that any alcohol consumption should be avoided, but some of the international guidelines suggest that the modest consumption of 1-2 drinks is probably not harmful and many practicing obstetricians agree. The data to date have been quite variable and clearer guidelines have been needed. This has now been addressed by Lewis et al. in last week’s online published report in Plos One.

Their study as part of the Avon Longitudinal Study of Parents and Children included over 11,000 eligible parents and 6,000 eligible children. They hypothesized that the adverse effects of alcohol may be moderated by genetic variations in the gene that determines the rate of metabolism of alcohol. That is, the impact on the fetus would be inversely proportional to metabolic rates (slow metabolizers, high impact) and that even very modest intake of alcohol (1-6 drinks per week) might adversely impact the developing child, if the children were in the genetically at-risk group. They identified four genetic variants of the ADH gene that largely determine slower metabolic rate and looked for the impact on IQ at age 8. Controlling for the full range of variables, they found that there was a negative impact on IQ for each of the variant genes of approximately 2 points {−1.80 (95% CI = −2.63 to −0.97) p = 0.00002,}, with no effect among children whose mothers had the gene variants but abstained during pregnancy {0.16 (95% CI = −1.05 to 1.36) p = 0.80; p-value for interaction = 0.009}. With this new evidence, the advice to women with risk alleles who anticipate becoming pregnant or are pregnant should clearly be “do not drink at all,” there is no “safe” window.

www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0049407
Poor Outcomes for Adults 33 Years Later with Childhood ADHD

Children with ADHD suffer from a wide range of deficiencies in psychosocial and educational functioning. Previous conventional wisdom has long held the wishful thought that ADHD symptoms dissipate during adolescence and early adulthood, but studies of young adults diagnosed with childhood ADHD have demonstrated elevated rates of ADHD symptoms, substance abuse, antisocial personality disorder, and lower educational attainment. However, studies of adults with childhood ADHD have generally not extended beyond early adulthood.

To address questions about the impact of childhood ADHD past the third decade of life, Rachel Klein and her colleagues at the Child Study Center at NYU conducted a prospective, 33-year follow-up study with masked clinical assessments of 135 men with childhood ADHD, free of conduct disorder, and 136 men without childhood ADHD (65% and 76% of the original cohorts, respectively). Children were originally assessed at 8 years of age. The researchers tracked a wide range of psychosocial outcomes in the study participants. Adults with childhood ADHD attained an average of 2.5 years less education, and were much less likely to complete a bachelor’s degree or higher (19.3% vs. 64.0%) or be employed. Mean and median salaries of the men with childhood ADHD were nearly half of what their non-ADHD counterparts were making, and they were about thrice as likely to have been divorced (31.1% vs. 11.8%). The men were also more likely to have antisocial personality disorder and substance use disorders, but unlike children with ADHD, no more likely to have mood or anxiety disorders.

This research reinforces what most child psychiatrists know very well, that ADHD is a real and potentially disabling illness with ramifications well beyond adolescence. While research has not been clear on whether treatment of childhood ADHD mitigates any of these poor outcomes, child psychiatrists can use this information to educate families that the long-term consequences of childhood ADHD are real and may warrant intervention well beyond the childhood years.


Continuing to Clear the Murky Bipolar Waters

Defining, diagnosing, and treating the bipolar disorders have been among the most controversial of topics facing child and adolescent psychiatrists today. Data-driven rigorous studies are gradually beginning to clear the otherwise murky “beliefs” that all too often have clouded both clinical care and the press. In September’s Archives of General Psychiatry, Kathleen Merikangas and her co-workers have published a large epidemiological study of over 10,000 youths as part of the National Comorbidity Survey Adolescent Supplement (NCS-A). The NCS-A is a nationally representative face-to-face survey of adolescents aged 13 to 18 years which uses a modified version of the face-to-face Composite International Diagnostic Interview (CIDI) to generate DSM-IV diagnoses. Demographically, the sample was 51.3% male and 48.7% female. The mean age was 15.2 years with a slight skewing toward the younger aged 13, 14 year olds. The sample was 65.6% non-Hispanic White individuals, 15.1% non-Hispanic Black individuals, and 14.4% Hispanic individuals.

While the CIDI generates the full range of diagnoses, they supplemented it by adding measures of symptom severity among 12-month cases using a self-report version of the Young Mania Rating Scale (YMRS) for mania/hypomania and the Quick Inventory of Depressive Symptomatology Self-Report (QIDS-SR) for major depressive episode (that) were embedded in the diagnostic modules for mania and depression, respectively.

They found that 2.5% of youth met criteria for lifetime bipolar I or II disorder and 1.7% for mania only. Twelve-month rates of mania with and without depression were 2.2% and 1.3%, respectively. There was a nearly 2-fold increase in rates of mania from ages 13-14 to 17-18 years. Additionally, they found that 7.6% of 13-18 year-olds reported a lifetime diagnosis of major depressive disorder and the annual prevalence was 5.7%. Finally, 38% of the bipolar or mania only groups had a lifetime non-mood DSM diagnosis with a 12-month rate of non-mood DSM disorders of 29%. They also found that mania with depression was associated with a greater number of all indicators of clinical severity including symptom number and severity, role disability, severe impairment, comorbidity, and treatment compared with depression alone. Not surprisingly, suicide attempt rates were also highest in this mania with depression sub-group with 1 in 5 making an attempt.

The implications of the study are significant. First, the rates of bipolar I and II (2.5%) approximated the rates of bipolar I and II in adults, giving additional credence to the story that the majority of adults with bipolar disorder report that their illness started in adolescence. This adds to the previously limited epidemiologic data to date, and for the first time establishes a substantiated prevalence rate for bipolar I and II. Their study also suggests that there may need to be a reframing of this set of disorders to include a category of “mania only.” Although there is substantial attention to irritability as a manifestation of mania, there has been limited research on the mood elevation/activation dimension underlying mania that was manifested by the majority of adolescents in the present study. This adds to the work of Liebenluft and others who have been teasing out the irritable/explosive patients from those with true bipolar disorder where the hallmark is clear mania or hypomania. Finally, for those youths with mania/hypomania and depression, they identified a group particularly at risk for suicide (1/5) and marked dysfunction that should be targeted for the most intensive follow-up.

continued on page 20
Vitamin D Deficiency Common in Adolescents with Mental Illness

The prevalence of vitamin D deficiency, especially in racial/ethnic-minority populations, has become a greater focus for public health research, with 50% of all teens (and 90% of African-American teens) having low vitamin D levels, with 9% of all teens having such low levels that they qualify as deficient. Vitamin D has an important role in central nervous system (CNS) development, with vitamin D receptors and activating enzymes prominently functioning at the hypothalamus, substantia nigra, and even in glucocorticoid signaling in the hippocampus. Vitamin D receptor knock-out mice demonstrate more anxiety and depressive symptoms.

Barbara Gracious and her colleagues at The Ohio State University measured vitamin D levels of 104 adolescents presenting for acute mental health treatment over a 16-month period and compared this to the severity of illness at the time of presentation. Thirty-four percent of the youth presented with vitamin D deficiency and 38% with insufficiency. Youth with vitamin D deficiency had significantly higher risk for psychotic symptoms (OR 3.5, p<0.009), even when controlling for race.

While the results of this study are preliminary and do not establish a clear mechanism between vitamin D deficiency and a greater risk for psychotic symptoms, vitamin D deficiency is easy to screen, and easy to treat with potential consequences for CNS development and mental health. Clinicians should consider whether screening and treating for vitamin D deficiency should become a routine or focused intervention in their clinical practice, especially in more severely impaired youth who are getting routine evaluation of laboratory values for medications that require special monitoring.


www.biomedcentral.com/1471-244X/12/38

The American Medical Association (AMA) Recommends Further Research and Guidance on the Use of Atypical Antipsychotic Medication

In November, the American Medical Association’s House of Delegates adopted a report recommending that the National Institute of Mental Health (NIMH) assist in developing guidance for physicians on the use of atypical antipsychotic medications in pediatric patients, and to encourage ongoing federally funded studies on long-term efficacy and safety.

The report was written after a resolution from AACAP, the American Psychiatric Association, and American Academy of Psychiatry and the Law requested that the AMA conduct a review of the data on the use of antipsychotic medications in children and adolescents and to provide guidance to physicians and parents on appropriate use. The report, written by the AMA Council of Science and Public Health, evaluates the most recent data to address safety and appropriate use of these medications, including the complex issues surrounding use in pediatric patients. AACAP’s guidelines and other clinical recommendations are referenced as well. To view the report, www.ama-assn.org/assets/meeting/2012i/i12-ref-comm-k-report.pdf.

Louis Kraus, M.D., AACAP delegate and member of the Council on Science and Public Health, testifies about the importance of the report in advancing the research on the effects of these medications on pediatric patients.
AACAP’s Douglas B. Hansen, M.D.
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Why do you like the evening tide?

Kieran D. O’Malley

Why do you like the evening tide?
The raven sang as it circled
menacingly close to her head,
She looked up momentarily and smiled,
Then walked further into the oncoming waves
the side of her face transfixed in a luminescent sunset.
Increasingly the rhythmical crashing of the waves
drowned out the rapidly muting voices from the shoreline.
She was past coldness now,
Her heart racing in unison with the wind and the waves.

Why do I like the evening tide she thought again,
Because it brings on the coming night
and closes this long day’s journey.

The raven circles once more,
The sun sets once more,
The waves crash upon a Baile’s strand once more,
But the lone woman is not seen once more.

Dublin, July 9th 2011
(Inspired by Brendan Kennelly’s ‘Picture’)

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

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, M.D., at crjoy1@gmail.com.
The Cabala of the Animals
■ By Jane Simon, M.D., illustrated by Jim Whiting

CreateSpace Independent Publishing Platform, 2012
92 pages - $9.99 (paperback)

Child psychiatrist and psychoanalyst Dr. Jane Simon writes that the word Cabala signifies “the act of Giving and Receiving,” a perfect summation of the gifts given and received in the therapeutic relationships shared between animals and people. Dr. Simon’s subtle poems and witty epigrams accompany playful cartoons and photographs, illuminating seemingly simple yet sophisticated life lessons, evoking a sort of playful cross between William Carlos Williams and The New Yorker. Dr. Simon writes a weekly blog as well (drsimonsays.blogspot.com), which includes a picture of her schipperke named Woolf, a therapy dog at the Good Dog Foundation, dressed smartly in a sailor costume.

Widowers Beware: How to Survive and Thrive
■ By Max Sugar, M.D.

Self-published, 2012
194 pages – $16.95 (paperback)

Retired child and adult psychiatrist and impressionist artist Max Sugar writes a poignant guide book / cautionary tale for new widowers looking to live full lives and gain access to good feelings while managing their newly discovered vulnerabilities. Dr. Sugar speaks from firsthand experience as well as from years of working with patients navigating similar conflicts of ego integrity and despair, returning to the dating scene, and forming new lives and loves. Check out Dr. Sugar’s artwork at www.maxsugarart.net.

The Children’s Hour
■ By Kenneth S. Robson, M.D.

Lyre Books, 2010
160 pages – $24.00

After years of treating hundreds of children and adults with psychotherapy, Kenneth Robson has assembled a cohesive and carefully crafted series of vignettes spanning a half century career in child psychiatry. Rather than focusing on diagnoses, Dr. Robson progressively traces the phases of normal development by carefully selecting episodes from his therapy experiences that highlight the conflicts inherent even to healthy human development. He embraces his own feelings and experiences in psychotherapy and crafts vivid scenes and images, allowing the reader access to the drama, humor, shame, and compassion that permeate the therapeutic alliance in the psychotherapist’s office.

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.
Adolescents with Autism Spectrum Disorder: A Time of Challenge and Opportunity

Arshya Barati Namin
Vahabzadeh, M.D.

Our society’s understanding of autism has evolved over the last decade. Autistic disorder, in the Kannerian sense, has gradually given way to the concept of Autism Spectrum Disorders (ASD). This conceptualization has contributed to the recognition of Autism in the U.S. population and has greatly increased the number of people beneath this diagnostic umbrella. ASD is a greater presence in the media and our societal consciousness. Individuals with ASD have moved into the media mainstream. This mainstreaming of ASD is facilitated by a range of television shows, fictional films, and documentaries. In addition, media highlighting ASD is being produced by individuals with ASD that reflects their unique viewpoint.

ASD is now thought to affect 1 in 88 children in the United States. Societal and scientific recognition of this greater prevalence has made ASD one of our most discussed health conditions in the public square. ASD advocacy groups and individuals with ASD have created a movement that continues to gain momentum and as such in increasing positive political and legislative attention to constituents’ concerns.

An increasing number of individuals with ASD, who were diagnosed as children, are presented with unique challenges when transitioning through adolescence and into adulthood. Adolescence, as many would agree, is peppered with a plethora of social, emotional, and life challenges. Overcoming such challenges requires adolescents to demonstrate flexible and increasing social awareness; both of which are areas of considerable difficulty and anxiety for people with ASD. While great biological and cognitive developments are witnessed in adolescence, the adolescents with ASD are challenged by fundamental questions such as “Who Am I, and What Can I Be?”

Individuals are Unique but Many Challenges are Universal

I am often asked by both children with ASD and their caregivers, “What are the teenage years going to be like? What should I (we) expect?” Given the heterogeneity of ASD and the intrinsic uniqueness of each person, these questions are particularly difficult to answer. I find offering guides written by authors with ASD to help others cope with the challenges of adolescence, such as Freaks, Geeks & Asperger Syndrome: A User Guide to Adolescence, and The Aspie Teen’s Survival Guide: Candid Advice for Teens, Tweens, and Parents, from a Young Man with Asperger’s Syndrome. I believe that such books help teens and their caregivers realize that they are not alone.

Despite the intrinsic uniqueness of the individual adolescent with ASD, many face common challenges. Adolescents with ASD may have difficulties coping with schoolwork, developing social relationships, and making the transition through puberty; these are some of the common concerns. As child and adolescent psychiatrists, we should, however, attempt to ensure that we do not overlook some of the more subtle, yet potentially distressing experiences that teenagers with ASD may undergo. Adolescents with ASD may find themselves being picked last for sports teams, being isolated from social events, and struggling with the universal adolescent aim of “fitting in.” Self-esteem may be an issue for many adolescents with ASD. I find that helping to support their self-esteem and establish their sense of identity may be aided by books such as Different Like Me: My Book of Autism Heroes.

Recent research has highlighted that 61 percent of children and adolescents with ASD have been bullied. Monthly rates of bullying demonstrate a three-fold higher rate in individuals with ASD compared to their non-ASD peers. Notably, individuals diagnosed with Asperger’s syndrome, a variant within ASD, have the highest rates of being victims of bullying (Anderson 2012), and may be at particularly high risk of internalizing the distress associated with bullying (Carter 2009). This internalization may lead to long-term problems with depression and anxiety. I have found resources, such as the Autism Speaks Combating Bullying website (autismspeaks.org/family-services/bullying), provide valuable information regarding bullying of special needs children and adolescents. As professionals, we need to be aware of the prevalence of bullying in this population and should seek to help families and schools develop strategies not only to identify children being bullied but to create safeguards that will prevent its occurrence.

Communicating with Computers

Given the difficulties with social interactions and aided by the increasing accessibility to the internet, some adolescents with ASD engage other people through online communication. Communicating online through Facebook, e-mail, or instant messaging may be particularly useful for people with ASD as it removes the need for eye contact and the verbal intonation of spoken language, and is more structured (Burke 2010). One study noted people with ASD preferred e-mails as the communication modality of choice when speaking to both friends and non-friends. They also enjoyed using online forums to discuss their hobbies and to connect to other people with ASD (Benford 2008).
Adolescence is a time of transition, for many people with ASD exactly what they are transitioning to may be unclear. People with a greater level of impairment may be transitioning to more structured accommodation, with new services being provided for them. People who are higher functioning may be looking to develop skills or find employment. An increasing number will be looking at further education, with the prospect of college. A website, Autism after 16, has been established to help provide information in regard to the transition to adulthood for teenagers with ASD.

Articles written by people with ASD discuss housing options, employment, and financial resources (www.autismafter16.com). It is evident that the process of the adolescent with ASD transitioning to adulthood would benefit from coordinated planning and involvement of multiple invested individuals, which includes the person with ASD.

Final Thoughts
Adolescence is filled with challenges. We should attempt to deepen our understanding of the issues faced by individuals with ASD as they transition through adolescence into adulthood. By improving our personal awareness and proactively anticipating problems, we will be in a unique position to offer guidance and resources to people with ASD, helping them in achieving their potential.

References


Dr. Vahabzadeh is a PGY-3 psychiatry resident at Emory University. He is also an APA Leadership Fellow, an ACP 2013 Laughlin Fellow, the associate editor of the American Journal of Psychiatry Residents Journal, and an AACAP Educational Outreach Program Awardee. He has a special interest in Autism Spectrum Disorders. He may be reached at arshya.vahabzadeh@emory.edu.

Call for Papers
AACAP’s 60th Annual Meeting takes place October 22-27, 2013, at the Walt Disney World Dolphin Hotel in Orlando, FL. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by Friday, February 15, 2013, or by Monday, June 17, 2013 for (late) New Research Posters. The online Call for Papers submission form is available on www.aacap.org and all submissions must be made online. Questions? Contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

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OCTOBER 22–27, 2013 • ORLANDO, FL
WALT DISNEY WORLD DOLPHIN HOTEL
Mark Borer, M.D.

A
s child and adolescent psychiatrists, we are well-trained, advanced-specialty physicians. For those of us in traditional private practice roles, we have performed valuable psychiatric formulations and assessments for children and families, and have delivered a unique blend of psychopharmacology and therapy interventions within our offices, as well as consultative and treatment services at other facilities where we may hold contracts.

At this time, mental health service delivery is poised for big changes. Child and adolescent psychiatrists (CAPs) will continue to perform psychiatric assessment, medication/therapy follow-ups, and multidisciplinary service delivery of therapy, oversight of wellness, and access to care, along with other mental health service professionals and mental health administrative professionals.

For those CAPs in private practice who are willing, we are called upon for additional help in increasing access to care, including consultation to school systems, collaborative relationships with advanced practice nurses, and collaborative relationships with primary care physicians through primary care consultation (involving online or in-person work using digitalized forms, and/or telemedicine). Through the use of electronic interventions, services by child and adolescent psychiatrists can be offered on- and off-site in youth detention programs, alternative school programs, and specialty services for the intellectually and socially disadvantaged.

Private practice psychiatrists will also form bridges to medical homes and accountable care organizations (ACOs). CAPs continue to offer clinical formulations, psychopharmacology, and therapy interventions for specialized and complex patients and families, and help to integrate service delivery within community systems of care.

Private practice CAPs offer clinical supervision and consultation to clinical and administrative professionals. These services may be delivered within our private office settings, or onsite at the agencies where we consult. Reasonable reimbursement of the child and adolescent psychiatrist benefits both clinical and administrative agency components. CAPs should ideally be viewed as “growth agents” for the practices and agencies where we work.

Private practice CAPs have a unique leadership role, both in the private office and at our consulting agencies. By nature of advanced training, integrative and collaborative approaches, and breadth of knowledge brought to mental health teams, the CAP is always in a leadership role on each team on which he or she serves, bringing value to the designated clinical or administrative team leader on those teams where the CAP is not the designated leader. A special skill is to link and to help the team to transcend the separate inputs of a medical model and greater biopsychosocial components. This service is needed in both the private office, and when offering service to outside agencies.

As the supply of CAPs continues to diminish relative to the demand, we see more opportunities for a consulting role for the private practice CAP, linking with additional mental health professionals. However, the concept that by collaborating with other professionals this will somehow minimize the need for child and adolescent psychiatric service hours seems misguided. The more that additional professionals are brought in to develop and staff systems of care, the more these systems will require access to child and adolescent psychiatric training and acumen to collaborate and help with the most difficult children and families. Thus, your private practice and outside agency consultation slots are likely to be in demand.

Moving forward, private practice CAPs will continue working with the sickest, most difficult, and most complex of our patients and families. We will continue to develop appropriate scientifically guided psychopharmacology interventions, as well as ways to integrate these interventions with other behavioral, therapy, and community interventions as we expand our service delivery through collaboration with other teams of professionals. In return for what is likely, over time, to be an increasing hourly rate for service contracts and increased reimbursement under service codes for CAPs, we are likely to deliver value — whether it is in direct care, collaborative care, administrative work, or as a liaison. Each of us wants to help and we have sacrificed and continue to sacrifice a lot to do.

As we move our private practices toward more community integrated forms of care delivery, I believe we will be ever more in demand if we remain flexible and available. Whether service is delivered onsite at our private offices, or at outside contracted agencies, opportunities continue for the private practice CAP. Extra time is still needed to advocate for our patients, including through our active participation with our AACAP regional organizations. These Regional Organizations of Child and Adolescent Psychiatrists (ROCAP), the AACAP website, and the AACAP Annual Meeting remain major sources of support and connections for private practice CAPs within our field. Practice tools to help with primary care consultation, collaboration with schools, and with advanced practice nurses have been developed through AACAP, as well as through the efforts of other private practice CAPs. These tools are available to assist you in these transitional times. Together we will maintain the best of what private practice has been, and embrace what it will become.

Dr. Borer is a board certified child and adolescent psychiatrist, as well as a general psychiatrist. He specializes in psychopharmacology, family therapy, and collaborative care. His private practice, Psychiatric Access for Central Delaware, P.A., is in Dover, Delaware. He currently serves as the secretary-treasurer of the ROCAP. He may be reached at bugglinborer@comcast.net.
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The Richness That Is the Academy: Virginia Q. Anthony (“Ginger”) at the 2012 Karl Menninger Plenary

Diane K. Shrier, M.D.
Contributing Editor

The following is taken from Ginger’s remarks. Ginger, now an Honorary Member of AACAP, will continue to move AACAP’s mission forward as a volunteer, primarily in the area of development. Typical of Ginger, her focus is primarily on the contributions of others, rather than on what she has done or contributed to AACAP’s mission.

Thank you, AACAP, for an amazing 39 years of growth and achievements (1973-2012). I will share with you personal reflections on highlights of our history. There isn’t time to describe all the Academy’s accomplishments, the many relationships with members and staff, who have become friends and “family,” and the fun of being part of AACAP.

I interviewed for the Academy position with three presidents and Bill Stone, M.D., who then managed the AACAP Annual Meeting. Halfway through my fourth interview Dr. Stone asked, “Hey, what do you want to be when you grow up?”, and I said: “I wouldn’t have known if you asked me three weeks ago, but since then my son Justin and I have been on a lion-country safari. I want to be a lion.” Amazingly, then-president, Al Solnit, M.D., hired me.

When I joined the Academy, we had 1,800 members, now about 8,500. We had a budget of $137,000, now about $8,000,000 and a staff of three, now 38. The issues at that time were membership, the Annual Meeting program, and the Journal.

In my 11th year at the Academy, I married E. James Anthony, M.D., then-past-president of the Academy. So much of the Academy’s history bears James’ imprint. He is an extraordinary child psychiatrist, child analyst, and researcher; and he was sought as a speaker throughout the world, not only for the substance of his work, especially on resiliency and the invulnerable child, but for his ability to convey empathically the essence of a child and to build on the positive. When he spoke, clinicians in his audience felt proud of their own work and of the specialty of child psychiatry. On James’ first day as president in 1981, AACAP went to Mexico to begin a long friendship with AMPI (Association Mexicana de Psiquiatría Infantil), our sister organization in Mexico. Each year the president, executive director, and others with interests in cultural diversity traveled together to another country, making connections with child psychiatrists and sister organizations.

I will briefly mention four members among many who have previously been recognized for extraordinary leadership to the Academy (the first three were acknowledged at our 50th anniversary): Paul Glass, M.D., Norbert Enzer, M.D., Bennett Leventhal, M.D., and Jeanne Spurlock, M.D. Paul Glass, our official photographer for 30 years, took thousands of photos documenting our history. Norbert Enzer coordinated and was primary author of both Project Future and our Code of Ethics. Bennett Leventhal has been dedicated to the Annual Meeting program for over three decades, including mentoring and collaborating with first-time submitters. Bennett also played a pivotal role in establishing the Academy’s Office of Research. He started our K-12 research program and was principal investigator for the prototype, first with NIMH (National Institutes of Mental Health) and later with NIDA (National Institute on Drug Abuse). The Academy selects five young, new researchers each year for this $1.5M per year program; supports them with stipends, project support, and local and national mentors for five years each. Also, 10 years ago, Bennett took a leadership role in managing the Academy’s relationship with the pharmaceutical industry, identifying a need to take control of these relationships, defining when and under what circumstances we would collaborate with them.

Jeanne Spurlock was an outspoken advocate for children and for minorities. She served for many years as the deputy director for Minority Affairs of the American Psychiatric Association. Whenever any policy issue or program was mentioned and someone spoke of patients, her arm would shoot up: “And are some of those patients children?” “And are some of those children minorities?” “And do some of those patients live in non-traditional families?” After a while, people would see Jeanne at a meeting or even when she wasn’t in the room, and say, “patients, including children, some of whom are minorities, and some of whom come from non-traditional families.” The Academy with NIDA and NIMH started fellowships for minority medical students and named these the Jeanne Spurlock Fellowships and later funded the Jeanne Spurlock Lecture at the Annual Meeting.

I want to highlight four historic achievements of the Academy in the area of Prevention. In the early 1970s, four Academy members (Alan Gurwitt, M.D., Carl Mindell, M.D., Steve Proskauer, M.D., and Thomas Halverson, M.D.) advocated against the practice of having Native American children adopted away from their families and their tribes. The Academy’s position statement successfully called for a halt to this practice and our work was recognized by many tribes and by federal and state agencies.

In the late 1970s, the Academy learned that Congress was about to relax standards for lead emissions in gasoline. Mary Crosby (AACAP deputy director and leader of our Congressional efforts for 25 years) and Academy member David Fassler, M.D., drafted a position paper about the effects of lead on mental retardation and child development. All the associations in our child and mental health consortia adopted the Academy’s statement and successfully advocated against its passage, and millions of children have been healthier for it.
In the early 1980s, there was universal gloom within the Academy as insurance companies tightened payments and members saw themselves unable to compete with psychologists (100 times our numbers). At the urging of Frank Rafferty, M.D., the Academy established our first Work Group, on consumer issues, which started our Facts for Families and was the beginning of an outreach to parents. Facts for Families has been translated into multiple languages and our members have distributed them to countless thousands of parents, educators, and others.

In the early 1990s, managed care exploded in medicine. While other associations chose to fight managed care and lose, the Academy, led by Alan Axelson, M.D., sought to understand the decision making around managed care, and to partner and collaborate and help our members to establish effective treatments for better access and reimbursement. Also, Dr. Axelson and Andy Pumariaga, M.D., and others, knew that eventually Medicaid was going to adopt a managed care model. Many child psychiatrists feared that states would go for the cheapest proposals for delivery of care. The Academy crafted an RFP (Request for Proposal), which highlighted points that would be responsive to children with mental illnesses. Our RFP was shared with all state Medicaid directors and several states adopted our work, word for word, showing how our group could really influence systems. The Academy provided models of levels of systems of care necessary for good mental health treatments for infants, children, and adolescents, which have been adopted by several states. Our passionate and experienced advocates leveraged the specialty of child and adolescent psychiatry beyond its relatively small numbers.

The Academy has focused on development issues in a significant way. During Jerry Wiener, M.D.’s presidency, the Academy received a bequest from Norbert Rieger of $5,000 annually, and my notion of a $5,000 award recognizing the best research in the Journal was accepted. Stan Leiken, M.D., and his wife Barbara and Peter Tanguay, M.D., and his wife Margaret, have supported two more awards; and Owen Lewis, M.D., through a parent’s generous contribution, established the Elaine Schlosser Lewis Award for research on attention-deficit disorder. Now the Academy annually gives many $5,000 awards for outstanding research, treatments, and clinical leadership, which convey a message to the recipients to continue their good work and to show appreciation to the donors. I leave the Academy with $3.8 million in endowed or funded programs. Most recently, the Academy started the Virginia Q. Anthony Fund, which already has received over $60,000.

The Academy remains financially healthy, in part, because in 1983, through the leadership of Bob Stubblefield, M.D., E. James Anthony, M.D., Bill Stark, M.D., and Larry Stone, M.D., and Marnette Stone, we purchased our headquarters building outright, a wonderful 14,000 square foot building, currently valued at about $5,000,000.

Finally, I want to acknowledge three staunch personal advisors. I often cite the benefits of serving under multiple presidents, receiving the equivalent of a new MBA every two years. But three individuals have provided Ph.D.s to me over many years: Bill Stark, M.D., Richard Sarles, M.D., and John Showalter, M.D., have provided astute advice, with humor, on the art of the possible.

When I gave my final report to Council this past June, it was short. I spoke of my legacy to the Academy, embodied by my two sterling deputies, Kristin Kroeger Ptakowski, director of Government Affairs and Clinical Practice, and Heidi Büttner Fordi, then the director of Continuing Medical Education and Development and now the new executive director of AACAP. Both joined the AACAP staff about 17 years ago.

Kristin had previously worked for NAMI (National Alliance for the Mentally Ill), so she knew the issues on the Hill, and worked hand in hand with Mary Crosby. Kristin educated us on the nuances of the Hill and how to get things done. She carries tremendous stature with the professional associations, especially AAP (American Association of Pediatrics) and APA (American Psychiatric Association) and with parent advocacy groups. Our issues are now well known to Congressmen, Senators and their staffs, the White House, and federal agencies.

At this Annual Meeting, the Academy celebrates the new executive director, Heidi Büttner Fordi, who brings many skill sets and a wealth of experience to the position. For 17 years, she has mastered the CME (Continuing Medical Education) system, international dialogue and collaboration with our international affiliates, and management of the Annual Meeting. She knows the science and politics, and will skillfully lead forward the richness that is the Academy.

Dr. Shrier is clinical professor of psychiatry and pediatrics, George Washington University Medical Center, Washington, D.C., and contributing editor to the AACAP News. She may be reached at dianeshrier@rcn.com.
Check out the 59th Annual Meeting photos here: www.aacapphotos.com/receptions_2012/

Photos by Fred Seligman, M.D.
Check out the 59th Annual Meeting photos here: www.aacappphotos.com/receptions_2012/

Photos by Fred Seligman, M.D.
Residents and early career psychiatrists had a plethora of events and sessions to choose from to make the Annual Meeting valuable, relevant, and enjoyable. Included in this were annual offerings such as the mentorship program for residents and the member services forum for early career psychiatrists. Here we highlight three events that were offered at this year’s Annual Meeting: the first two feature brand new formats geared specifically for residents and early career psychiatrists, and the third an annual session that is consistently well-received and attended.

The Poster Docent: A Guided Tour of Selected AACAP Posters

AACAP’s Annual Meeting got off to an exciting start with a new program related to the New Research Poster Sessions. Jonathan Posner, M.D., a research psychiatrist from Columbia University, was selected by the Program Committee as the “poster docent” and led a discussion illustrating important points about functional neuroimaging. Dr. Posner used nine posters about neuroimaging to discuss methodology, research design, sample size, preparation of the patient and family, challenges of getting scanner time, examples of costs involved, and the data analysis required to generate the images, as well as how to interpret the findings statistically. Laurence Greenhill, M.D., chair of this event, commented that this novel format was extremely successful and provided attendees with new skills and strategies for critically assessing posters viewed throughout the meeting.

Previews from the Pipeline: A Data Blitz Featuring Early Career Investigators

This program was chaired by Tamara Vanderwal, M.D., and Thomas Fernandez, M.D., of the Yale Child Study Center. An audience of 169 trainees, clinicians, and researchers were treated to a completely new and innovative format. Early career child and adolescent psychiatry investigators presented their cutting-edge research in a fast-paced, high-yield “data blitz” format, consisting of eight presentations that were each given in just seven minutes, with three minutes of question and answer (Q&A) time for each presenter. The Q&A was moderated by a panel of well-established investigators and clinicians in child and adolescent psychiatry, which included Matthew State, M.D., Ph.D., F. Xavier Castellanos, M.D., Barbara Coffey, M.D., Daniel Pine, M.D., and James Leckman, M.D. Audience members were also invited to ask questions using a real-time virtual question room that was accessible through Wi-Fi. The investigators presented an array of topics including pharmacogenetics in ADHD, prenatal stress and neural development, and glutamate and GABA function in autism. All present agreed that this session was incredibly effective. The investigators delivered presentations that were extremely efficient, organized, and informative. Audience members enjoyed the fast pace, and appreciated the exposure to cutting-edge research being conducted by these exceptional early career investigators.

Medical Students and Residents: Career Development Forum

This forum was sponsored by the AACAP Committee on Medical Students and Residents and chaired by Myo Myint, M.D., and Alex Strauss, M.D. It featured advice and guidance from experienced child and adolescent psychiatrists on many topics, including advocacy, career and family, ethics, contract negotiations, publishing research, and others. The conversations were very lively and featured the equivalent of “speed dating for psychiatry” where residents/students would move to a new table every 15 minutes to get to a new topic. The forum was heavily attended by medical students and residents, and many remarked on how positive and helpful the advice was. The vibe was definitely one of excitement for these future child and adolescent psychiatrists!

AACAP is committed to its resident and early career psychiatry members, and continues to develop new programs with this vital constituency in mind. Thanks to these three events, along with the many other events held throughout the meeting, residents and early career psychiatrists had ample opportunities in San Francisco to seek career guidance and develop their skills as child and adolescent psychiatrists.

Dr. Shaffer is assistant professor in the departments of Pediatrics and Psychiatry and Behavioral Sciences at the Albert Einstein College of Medicine. Dr. Shaffer served on the AACAP Program Committee as a resident member. He may be reached at scott.shaffer@einstein.yu.edu.

Dr. Herringa is assistant professor of Child and Adolescent Psychiatry at the University of Wisconsin School of Medicine and Public Health, as well as adjunct assistant professor of Child and Adolescent Psychiatry at the University of Pittsburgh School of Medicine. Dr. Herringa serves on the AACAP Program Committee. He may be reached at herringa@wisc.edu.
Psychosomatic Medicine at the Annual Meeting: A Recap

The 59th Annual Meeting of AACAP in San Francisco was a whirlwind of activity, and for the two of us, covering the entire amount of ongoing activity related to the interaction of psychiatry and physical health made the week an exhilarating scavenger hunt. Topics were myriad and reflected the depth and breadth of ongoing research, psychodynamic, and systems-of-care interactions between psychiatry and traditional medical care. Along with numerous posters, well over a dozen informative workshops, symposia, clinical perspectives, special interests groups, and institutes were sponsored or co-sponsored by the Physically Ill Child Committee, the Committee on Collaboration with Medical Professions, and the Training and Education Committee. At a meta-level, this mirrored the highly interactive and collaborative nature of pediatric psychosomatic medicine.

What follows is a summary of the highlights of the Annual Meeting for us, but this is only a snippet of the information that was presented.

An informative symposium dealt with mechanisms of action of different treatments for mood and anxiety disorders. Data were presented regarding D-cycloserine, a partial N-Methyl-D-aspartic (NMDA) receptor agonist with efficacy in OCD and anxiety disorders. One of the speakers presented the case of a young man with refractory and disabling depression who had failed multiple medications. Cerebrospinal fluid (CSF) examination revealed GTP-cyclohydrolase deficiency (an enzyme required for synthesis of dopamine and serotonin). When a downstream metabolite (tetrahydrobiopterin, BH4) was provided exogenously, he had a remarkable response with remission of depression. This case illustrates the potential for using metabolic approaches to assess cases refractory to normal interventions. Other symposia covered antidepressant-induced manic symptoms in youth, a phenomenon that experts agree is difficult to predict and requires further study. Imaging data were prominent as well, and though multiple studies were presented, a symposium on the amygdala illustrated the complexity and connectivity of this brain region, both in healthy young people as well as in those at risk for psychiatric dysfunction.

Clinical Perspectives sessions also detailed an array of different studies and topics. These included sessions on treating co-morbid substance abuse and psychiatric dysfunction, delirium, catatonia, feeding, and eating disorders.

An innovative workshop dealing with the medical-psychiatric interface in youth was chaired by Eva Szitghely, M.D., Ph.D. Dr Szitghely’s research focuses on inflammatory bowel disease (IBD), Crohn’s disease, and ulcerative colitis, a common and incurable illness that is often diagnosed in children and adolescents. It is a fascinating model system for studying the connections between physical and psychiatric illness, because it has high rates of co-morbid depression that accompany the symptoms of the disease. She presented proof-of-concept data showing that a cognitive behavioral therapy (CBT)-based intervention for youth with depression and IBD has benefits in improving both depression and IBD severity. In addition, her group discussed ways to translate research on sleep disturbance and pain (both of which are commonly seen in IBD) into interventions with the potential to improve co-morbid psychiatric and medical symptoms. This work highlights the powerful potential of translational research on delivery of care and has served as a blueprint for other integrated services for children with chronic medical illness.

Sleep disorders were a hot topic this year. A day-long institute on pediatric sleep disorders exemplified the interaction that exists between psychiatric continued on page 34
and medical illness, with sleep being a symptom that bridges the gap. Experts presented practical information on managing sleep problems in children with ADHD, autism, mood disorders, parasomnias, and apnea syndromes. A symposium on mind and body presented information on circadian rhythms and emotional distress, sleep pattern irregularity as a predictor of suicidal risk, and the use of a combined CBT for insomnia and depression in youth with depression.

The rapid evolution of the pediatric medical home and the bi-directional influence of child psychiatry in its development was the focus of multiple presentations. Various models on delivery of care were presented ranging from consultative arrangements, statewide rapid triage and access programs, embedded services, primary prevention for at-risk populations, and collaboration with advance nursing practice for the use of telemedicine. It was heartening to see so many creative and innovative approaches. Policy implications, business, and reimbursement challenges were topics of debate and reflected the need for further research and multidisciplinary partnerships to promote the growth of sustainable programs. The unique skill sets of the child and adolescent psychiatrist as an educator, leader, and advocate will undoubtedly be key to these endeavors, in turn sculpting the future of our profession.

The Simon Wile Symposium on Consultation Psychiatry was, as it tends to be, a microcosm of the evolving roles of child and adolescent psychiatry as an integral aspect of the care of children and their families. Barry Sarvet, M.D., spoke about the Massachusetts Child Psychiatry Access Project (MCPAP), an innovative program that provides consultation, care coordination, and educational services to pediatric primary care clinicians, enhancing their ability to address mental health needs of their patients. This project demonstrates the ability to provide access to large populations in a clinically and fiscally effective manner. Jennifer Havens, M.D.’s presentation highlighted the escalation in the use of medical emergency departments for the provision of mental health care, reflecting the lack of appropriate mental health resources in many communities and the burden placed on already taxed systems, on patients, their families, and providers. Dr. Havens also reviewed a number of strategies for operationalized triage and access routes to community- and hospital-based services, along with the challenges inherited in their implementation. Patricia Ibeziako, M.D., from Boston Children’s Hospital presented the novel implementation of standardized clinical assessment and management plan as an organic self-improving quality and service delivery method in consultation-liaison (CL) psychiatry. Dr Ibeziako presented the successful implementation of this model in the hospitalized child with somatoform disorders, a turbulent dynamic in which the patient, family, and medical provider interaction is often extremely challenging.

This year, the Simon Wile Award on Consultation Psychiatry went to Maryland Pao, M.D., clinical director, NIMH and chief of the Psychiatric Consultation Liaison Service (PCLS) in the NIH Clinical Center. Dr. Pao’s award presentation reflected on the changes (and sometimes unchanging) aspects of the care of children in the interface of medical and mental health care, including historical perspectives and how our current work is standing on the shoulders of giants “to make psychiatric understanding of sick and healthy children and their families an integral part of the pediatricians” [and adult psychiatrists] thinking and acting.” (Kanner 1937; *Pao 2008). Dr. Pao also shared her own career path, demonstrating how psychosomatic medicine offers a multitude of opportunities for personalized education and growth, research, impact on systems of care, leadership, and, ultimately, a balanced and rewarding career.

Of course, this brief synopsis barely scratches the surface of all the information presented in San Francisco on the interface of psychiatry and medicine. Suffice it to say, there is a great deal of translational science, medical care, policy, and advocacy ongoing among AACAP members. The future looks bright.

Dr. Benhayon is a graduate of the Triple Board Program at the University of Pittsburgh and is currently a T32 post-doctoral fellow at the University of Pittsburgh, pursuing a translational research career studying the interaction between sleep and inflammation in chronically ill youth. Dr. Benhayon can be reached at benhayon@upmc.edu.

Dr. Ortiz-Aguayo is a graduate of the Triple Board Program at the University of Pittsburgh and is currently the medical director of the Pediatric Behavioral Health Consult and Liaison Services at Children’s Hospital of Pittsburgh of UPMC. He is also associate director for Residency Training for the University of Pittsburgh. He is a member in AACAP’s Physically Ill Child Committee and a component member in the Training and Education Committee. He can be reached at ortirx@upmc.edu.
Bird Song to Beethoven: Understanding Social Context and Developmental Processes

Judith A. Crowell, M.D.

We heard snippets of zebra finch song as we walked into the Founder’s Symposium: Social Context in Development on Tuesday evening, October 23rd, at the 59th AACAP Annual Meeting. The technician was testing the sound track for the upcoming lecture by Allison Doupe, M.D., Ph.D., on Lessons from Songbirds about Basal Ganglia Circuits, Social Context, and Learning. My time at the meeting ended four days later with the Lawrence A. Stone Plenary session where psychiatrist and concert pianist Richard Kogan, M.D., discussed The Mind and Music of Beethoven and (although I am not a music expert or critic) brilliantly and empathically performed three of the composer’s works for piano.

Despite the musical themes, on the surface there would seem to be little else to connect these two programs to each other, or even to child and adolescent psychiatry for that matter. Yet in retrospect, I was struck by several common features of the two presentations. Both Drs. Doupe and Kogan discussed topics of social relationships and context as key factors in development, trial and error learning (practicing), and deafness; one with respect to the developmental acquisition of mature and functional bird song, and the other regarding the development and musical evolution of a creative genius.

Bird song provides us a rare animal model for the development of speech, in which trial and error motor learning is elicited in social settings and for which hearing is crucial. Many male songbirds, including the zebra finch, learn their songs from their fathers. Through practice and hearing their parents and themselves, they gradually acquire an organized, shaped song. Each bird’s song stays relatively variable; that is, open to practice and “creativity,” until a female is present, in which case the song becomes much less variable and more on pitch when a “best” performance is given in the ritual to attract a mate. An infant bird that has damage to the lateral magnocellular nucleus of the anterior striatum (LMAN), a prefrontal cortex equivalent, cannot learn the song. An adult bird with equivalent disruption, for example through an infusion of a GABA solution into the LMAN, cannot change its song in response to new situations or stimuli. Thus the bird’s capacity to adapt to context is impaired by a specific injury to the brain.

After hearing Dr. Kogan’s remarks, it seemed to me that Beethoven had been deeply affected by experiences similar to those described for the songbirds. As a musical prodigy, both his grandfather and father instructed him. His father’s abusiveness and alcoholism contributed to his lack of social skills, anger, problems with authority figures, and inability to form relationships with women. Although his encroach- ing deafness nearly killed him through suicidal despair, Dr. Kogan suggested that Beethoven’s profound isolation from others also fueled his enormous creativity. He could not hear the works of other composers of his time. His experience of music and his audience was, for the most part, in his own mind. As a result, social and performance demands likely exerted less pull upon Beethoven than they did on his artistic peers, enabling him to break free of prevailing fashions and influences and to achieve a degree of musical evolution rarely seen in an individual artist.

I could be accused of drawing unfounded parallels between the human and animal worlds. However, between these sessions that framed my experience of the Annual Meeting, a number of presenters addressed the significance of social context and experience on development and behavior in both human and animal models, which suggests my ideas may not be totally off base. I was interested that Carl Feinstein, M.D., chose the topic of Child Psychiatry and the New Field of Social Neuroscience: Convergence or Missed Opportunity? for the Noshpitz Cline History Lecture. Dr. Feinstein expressed that the field of child and adolescent psychiatry should integrate and reintegrate developmental themes that emerged in the 1970s and 1980s regarding attachment theory, affect attunement, narrative assessment, and Theory of Mind. In the symposium, Who We Are: Evolution, Nonlinear Brain Dynamics, and Epigenetics Stephen Suomi, Ph.D., Walter Freeman, M.D., and James Leckman, M.D., also described the need for greater integration of evolutionary, biological, and psychosocial perspectives in the clinical practice of child psychiatry.

During this Annual Meeting, I attended sessions on development and brain functioning, assessed through various imaging techniques, EEG, transcranial magnetic stimulation, and animal models using genetic manipulations and infusions of neurotransmitters and hormones into brain areas, as well as through observations of behavior. Topics that “child psychiatry had turned away from” (C. Feinstein) in the 1990s are making their way back into our field through the integration of these new methodologies into previously existing research strategies.

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Many presentations, including those on songbirds and Beethoven, examined the developmental concept of sensitive periods, that brain maturation and certain types of learning are particularly sensitive to events or experiences occurring at particular developmental phases. In the Data Blitz session, Hanna Stevens, M.D., Ph.D., addressed the relations between a prenatal stress environment and fetal neural development. The session on Child Development and the Ecology of Risk addressed the impact of exposures to environmental toxins on the developing brain. In the symposium, Cells to Circuits to Community, speakers addressed the effects of early institutional care on brain structure and functioning, especially with respect to the amygdala. They noted that both early deprivation and timing of sensitive parenting interventions played key roles in developmental outcomes with respect to emotion regulation, anxiety, impulsivity, and hyperactivity. In Imaging the Amygdala in Healthy, High Risk, and Clinical Populations, speakers addressed more common psychosocial stressors as correlates of varying limbic system function and connections to the prefrontal cortex. These last two symposia addressed implications for social processing and learning, especially regarding fear and appraisal of, and over- and under-reactivity to, ambiguous stimuli as well as to real danger.

The symposium on Pathways and Risk Factors for Developmental Psychopathology and Wellness reported on birth cohort, family, genetics, and neuroimaging studies to conceptualize early risk factors for the development of psychopathology. In one of these presentations, Joan Luby, M.D., Deanna Brach, Ph.D. and Kelly Berton reported on hippocampal volume in school-age children being strongly associated with levels of maternal support received in the preschool years, a finding that had been previously observed in animal models.

From a more clinical perspective, several of the speakers in the symposium Gamma-Aminobutyric Acid (GABA) Dysregulation in Adolescent Depression described evidence that the childhood experience of abuse and trauma moderates depression and mania treatment responses. For example, in the TORDIA study, medication response was comparable in teens with depression only and depressed youths with abuse histories; however, trauma history predicted a worse response to cognitive behavioral therapy (CBT) (Shamseddeen et al. 2011). Evidence presented by Dr. Doupe, Nim Tottenham, Ph.D., and other presenters supports the hypothesis that the strong demands for change in cognitions inherent in CBT may not be compatible with the brain alterations associated with early trauma and adversity.

In a symposium on animal models of mental illness, J. Dee Higley, Ph.D., reported on a series of gene X environment studies with rhesus monkeys and alcohol use. Harking back to Harry Harlow and John Bowlby, monkeys who were peer-raised versus mother-raised were more likely to have greater consumption of alcohol when it was available, but this was most evident in those with heterozygosity (short and long allele) for the 5-HT transport promoter gene compared with those with two long alleles. Dr. Higley also noted that monkeys who were low-ranking in the social hierarchy were more likely to engage in high alcohol consumption. However, if these monkeys were subsequently placed in a setting where they had high social status, their alcohol consumption dropped dramatically.

Nancy Adler, Ph.D., in the Founder’s Symposium, echoed the importance of social standing in health outcomes. Pointing out that neither genetics nor health care access provides a satisfactory explanation for health disparities, she addressed topics of intrauterine environment, poverty, subjective social status, and the impact of cumulative adversity on physical health outcomes. She described her research findings that subjective social status predicts a number of health outcomes, including obesity and depression, controlling for the impact of poverty. She also discussed childhood trauma and adversity and their connections to health disparities. For example, retrospectively described childhood experiences, such as being abused, bullied, or exposed to domestic violence, have been correlated with premature reduction in telomere length in adult life, a process that is hypothesized to lead to earlier cell damage and death. (Telomeres are the repetitive nucleotide sequences that cap the ends of chromosomes and provide protection against loss of genetic information associated with DNA replication during cell division.) New Research posters by Andrea Danese, M.D., Ph.D., and my own research group addressed similar themes of childhood adversity and development of obesity in childhood and metabolic syndrome in mid-adults, respectively. Dr. Adler warned that growing socioeconomic inequality and associated adversity is not only a social problem, but has the potential to be a very significant public health issue.

Carl Feinstein and others speculated that, for a while, the field of child psychiatry seemed to lose track of developmental research in efforts to follow adult psychiatry in being more "medical," and in pursuit of specific diagnoses and psychopharmacological treatments. As an attachment researcher, I personally experienced this shift in focus and interest away from the basic science of child development. Consequently, I could not have been happier to hear bird song and Beethoven at this 59th Annual Meeting, and to see the re-emergence of interest in social context and developmental processes in recent years.

Reference

Dr. Crowell is a professor of Child and Adolescent Psychiatry at Stony Brook University on Long Island. She is also the director of training. Her research has focused on the development of parent-child and adult attachment relationships, and the impact of childhood relationships and trauma/adversities on adult physical and mental health outcomes. She may be reached at Judith.Crowell@stonybrookmedicine.edu.
Psychotherapy Presentations at the 59th Annual Meeting

Rachel Z. Ritvo, M.D.

At AACAP’s 59th Annual Meeting in San Francisco, attendees desiring psychotherapy programs frequently found themselves wishing they could be in two places at once as the rich and varied offerings vied for their time. The meeting kicked off with a sold-out Clinical Practicum on Tuesday, October 23, chaired by Alicia Lieberman, Ph.D., Patricia Van Horn, JD, Ph.D., and Robert Hendren, D.O., titled Child-Parent Psychotherapy in Early Childhood: Repairing the Effect of Early Trauma. On Sunday, the psychotherapy offerings concluded with a Clinical Case Conference, I Can’t Get Better Because You Will Leave, organized by Nicole Garber, M.D., of Baylor College of Medicine, Houston, Texas. What are the trends and factoids the meeting revealed about psychotherapy in child and adolescent psychiatry (CAP) circa 2012?

Workshops at the AACAP meeting are intended to teach skills. Over a dozen workshops on psychotherapy were offered and seven sold out. Those seven demonstrate the breadth of psychotherapeutic approaches in CAP: group, family, parenting, parenting groups, individual with parent, and individual. Some were strongly manual-based, but all were incorporating empirical, manualized approaches even when presented in the adapted form for “off label” or comorbid conditions. The theoretical orientations represented the multiple psychological traditions underpinning CAP: behavioral analysis, cognitive/learning theory, family systems, and psychodynamic theory from defenses through attachment theory and mentalization. Some workshops focused on children and others on adolescents. The most strongly behavioral approach was focused on autism. The parent-focused approaches were mainly addressing externalizing disorders. CBT, psychodynamic, and family approaches were applied to a broad range of comorbid conditions, anxiety, and trauma. Although we should always expect input from, and collaboration with, our psychology colleagues, it was gratifying to see how many AACAP members presented in the workshops. With limited space, I will just mention those who presented to sold-out workshops: Efrain Bleiberg, M.D., Regina Bussing, M.D., Judith Cohen, M.D., Mary Cook, M.D., Alice Mao, M.D., Suneeta Monga, M.D., and Laurel Williams, D.O.

Forward movement in the field of psychodynamic psychotherapy was presented in a well-attended, all-day Institute, Psychodynamic Psychotherapy in the 21st Century. Andrew Gerber, M.D., described advances in the quality of research studies of psychodynamic psychotherapy, placing it methodologically on a par with current cognitive behavioral therapy research. To achieve “evidence-based” status, studies of psychodynamic psychotherapy need to focus on replication trials and the challenge of finding the funding to develop second sites. Psychodynamic researchers also seem to have a preference for doing randomized trials against active treatments rather than inactive treatments, making it more likely that they will demonstrate comparability rather than superiority. Ted Shapiro, M.D., presented promising results of a small case series from the pilot study of Child and Adolescent Anxiety Psychodynamic Psychotherapy (CAPP) that he and Barbara Milrod, M.D., and their team at Cornell – Weill Medical Center have undertaken. The study is designed to parallel the Child/Adolescent Anxiety Multimodal Study (CAMS). CAPP is a time-limited, non-directive, manualized treatment for anxiety focusing on the dynamics underlying anxiety symptoms. The development of CAPP and the design of the study to parallel CAMS was stimulated by joint work of the AACAP Research Committee, the AACAP Psychotherapy Committee, and funding from Dr. Greenhill’s presidential initiative.

Lenore Terr, M.D., provided a research perspective grounded in years of careful clinical observation of the treatment of childhood trauma. She emphasized three principles of healing, context, correction, and abreaction, that organize her approach to treating childhood trauma.

AACAP’s Annual Meeting has evolved into an international meeting. This international flavor was evident in the

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psychotherapy offerings. Coming from the United Kingdom and affiliated with the Anna Freud Centre, Dickon Bevington presented Mentalizing-Based Therapy with Troubled Adolescents and Their Families at the Institute. Carol Hughes, a clinician-researcher in the psychodynamic arm of the United Kingdom’s IMPACT study of depression treatment for adolescents (Improving mood with psychoanalytic and cognitive behavioral therapies), described using parallels between parent-infant dynamics and psychotherapeutic containment to manage a severely disturbed adolescent girl in outpatient psychotherapy without medication after the patient had deteriorated in hospital and had been unresponsive or had severe side-effects on medication. At other events, the United Kingdom was represented by the Maudsley Hospital presentations on cognitive behavioral treatments for depression and for obsessive-compulsive disorder. Psychotherapeutic interventions for delinquent adolescents came from Switzerland (a mentalization-based treatment) and the Netherlands (Functional Family Therapy).

The meeting demonstrated a rich return on effort and investment from the SAMHSA National Child Traumatic Stress Network (NCTSN). Judith Cohen and Alicia Lieberman presented together at a Clinical Perspectives, The Role of Narrative in Treating Traumatized Children: Two Evidence-Based Perspectives. These two evidence-based treatments have been developed and disseminated with support from NCTSN. Also, a participant in NCTSN, Lisa Amaya-Jackson, M.D., M.P.H., recipient of the 2012 AACAP Norbert and Charlotte Rieger Service Program Award for Excellence, created in North Carolina, a statewide implementation platform to disseminate evidence-based trauma treatments through a training program that maintained fidelity to the evidence-based treatments while eventually reaching clinicians in 90 counties in her region. Dr. Amaya-Jackson’s work addresses the pressing demand to maintain quality and effectiveness of psychotherapy for children and adolescents while meeting the scale, or magnitude, of the need for treatment in our population.

While Dr. Gerber, in the Institute, discussed how fMRI studies of social brain function may eventually clarify the neural basis of the therapeutic changes seen in psychotherapy, the most intriguing and exciting look forward into the biology of psychotherapy was the Symposium, Who We Are: Evolution, Nonlinear Brain Dynamics, and Epigenetics, chaired by Douglas Kramer, M.D., M.S., and Stuart Copans, M.D. Particularly exciting were Stephen Suomi, Ph.D.’s studies of gene methylation and inflammatory responses in peer-reared rhesus monkey infants that changed to a more healthful pattern when the monkeys were placed with older, nurturant caregivers. Dr. Suomi has worked for many years on the genetics of social behavior in a colony of rhesus monkeys maintained by the National Institutes of Health.

The AACAP Psychotherapy Committee held two meetings during the Annual Meeting in San Francisco. Several AACAP members who are not serving on the Committee availed themselves of the opportunity, open to all AACAP members, to attend and join in the discussions. Among the many issues and projects on the Committee agenda, the plight of training programs that find themselves struggling to provide the psychotherapy training their CAP fellows desire, and the ACGME requires, has become a particular focus. In addition to working on creative approaches to filling gaps in the teaching faculty some programs face, the committee has begun to explore the third-party payment factors that interfere with fellows’ ability to carry psychotherapy cases.

For those who wish to know more about the many programs I was unable to review or any of the psychotherapies I have mentioned, I highly recommend that you explore the program abstracts on the AACAP website. I also expect that many of the presenters will bring updates to the next AACAP Annual Meeting.

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International Events at the AACAP 59th Annual Meeting

The 59th Annual Meeting in San Francisco, California, welcomed over 4,000 attendees. There was a significant attendance from international (non U.S.) registrants, numbering 916 participants from 48 countries. The AACAP Annual Meeting has become the largest in the world in child and adolescent psychiatry for international attendees.

The list of countries registering more than 30 participants was diverse and included Australia, Brazil, Canada, Germany, Netherlands, Norway, Spain, Sweden, and the United Kingdom. The other participants came from Algeria, Austria, Argentina, Bangladesh, Barbados, Belgium, China, Chile, Colombia, Costa Rica, Czech Republic, Dahomey, Denmark, Egypt, Finland, France, Iceland, India, Ireland, Israel, Indonesia, Italy, Japan, Korea, Lebanon, Mexico, Montenegro, Netherlands Antilles, New Zealand, Nigeria, Portugal, Puerto Rico, Qatar, Serbia, Singapore, Switzerland, Taiwan, Turkey, United Arab Emirates, and Uruguay.

All international participants were identified by country of origin in their ID badges, in order to facilitate recognition and networking, both with U.S. colleagues and with other international attendees.

International Presentations
There were many international colleagues co-authoring a full array of topics, and, in fact, presenting them in the scientific sessions. Major topics included global perspectives on bipolar disorder, child mental health, child protection and children’s rights, juvenile delinquency, international medical graduates’ training and contributions, and youth suicide and prevention programs. The presentations were spread across the week, were delivered through a range of formats, and were generally well-attended and received.

International Meeting Opportunities
The International Reception (Networking for International Attendees), sponsored by the AACAP International Relations Committee, held on Tuesday evening was well-attended with great fanfare. This reception now seems to have developed a strong tradition for attendance and interaction in a congenial social atmosphere; a highlight of the social program of the meeting.

Future Meetings
The AACAP Program Committee has two international members, in part to encourage the successful representation and scientific participation of international participants. Nevertheless, these applications are judged by the same standards of quality for inclusion as applications from the US. The Program Committee welcomes new international submissions and looks forward to the important participation of non-North American colleagues in Orlando, Florida, in October 2013.

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Annual Meeting: Behind the Curtains – Part 1
Annual Meeting Call for Papers: Why We Do What We Do

Gabrielle A. Carlson, M.D., Program Chair, and Jill Zeigenfus Brafford, C.M.P., M.T.A., Director of Meetings and Continuing Medical Education

Since I became chair of the Program Committee, I have been amazed at the effort that goes into making both the Annual Meeting and AACAP’s various Continuing Medical Education (CME) presentations throughout the year such great programs. For many years, in her role as director of Meetings and Continuing Medical Education, Heidi Buttnerr Fordi (now AACAP executive director) and her long time assistant director, Jill Zeigenfus Brafford, who has succeeded her, have been instrumental on the staff side in supporting the whole Program Committee; Bennett Leventhal, M.D., deputy program chair, and me. Collectively, we thought it would be educational and useful to do a three-part series on the Annual Meeting: Behind the Curtains to explain exactly how the Annual Meeting program is conceived and developed.

Decisions about the program really begin with the meeting itself. What worked, what did not work in the current program, and is there a new and interesting format that might be worth pursuing? The latter question is especially important for the Call for Papers, which is the first step in the Program process. It is my personal mission to make sure that the Annual Meeting not only includes “something for everyone,” but also that AACAP presents high-quality presentations and cutting-edge research that ultimately improves the care of our patients.

What Makes a Good Submission in Response to Call for Papers?
Each year, the Program Committee receives hundreds of program submissions and it is our job to review them and craft an Annual Meeting that balances the diverse needs of all of our members. A really good Annual Meeting program does not come from the Program Committee; it comes from you, the submitter, who puts together a good submission. If it were not for the high-quality submissions we receive from members and colleagues, we could not do our job of putting together a well-balanced, clinically relevant, high-quality program.

A good submission covers a topic of clinical or research interest; either in-depth or from a variety of viewpoints. The Program Committee is looking for submissions that are conceptually sound, with enough data and detail so that we can evaluate the submission’s merits. This detail is particularly important. AACAP requires more information on submissions than many other medical associations, but we do that to make our Annual Meeting the best possible scientific program. Submissions that do not have sufficient detail are often rejected simply because we do not have enough information about what you are trying to teach (i.e., the learning objectives of the program). I cannot emphasize enough how critical CME is to the Annual Meeting’s mission.

When developing a program submission, think about the topics that you want to know more about; if it is an issue for you, it is likely an issue for other child and adolescent psychiatrists as well. Our goal is to fill the knowledge gap of our members to ultimately improve their patient care, but we need you to help us identify those gaps and share with our members the knowledge and expertise that you have acquired in your professional career.

We welcome programs on all topics relevant to child and adolescent psychiatrists and have a variety of program formats to best convey your expertise. These include everything from Clinical Consultation Breakfasts and Special Interest Study Groups that are meant for small-group discussion on clinical topics, to Symposia and Clinical Perspectives that present data from diverse points of view, to Institutes that are full-day programs meant to give a comprehensive overview of a specific topic.

How We Select Programs
If you have presented at past meetings, you know that we have a detailed evaluation process that collects data on every presenter and presentation. The Program Committee carefully reviews these evaluations and uses the data when evaluating future presentations to improve your program experience year after year. We want the best presenters; those whose presentations are focused on learner outcomes and clinical relevance. For those of you who have never presented at the Annual Meeting, we encourage you to work with knowledgeable colleagues to help you flesh out your ideas; and feel free to solicit advice from Dr. Leventhal and me.

For anyone who has prepared a Call for Papers submission in the past, you know that we ask for a lot of details,
including if the submission addresses a practice gap, a detailed Review Abstract, a Proceedings Abstract that is published in the final program book, learning objectives, and speaker disclosures. You may wonder why we require all of this information. As an accredited CME program, we are required to use learning objectives, practice gaps, and disclosures to evaluate program submissions and make sure that research is free of bias and that the program goals focus on improved patient care. But more importantly, we need these details to understand the specifics of your submission to ensure positive learner outcomes for our members and confirm that we are providing topics of interest for all of our constituents. We know that there are many different ways our members practice and treat patients and that everyone has different educational needs. It takes considerable thought to evaluate the submissions to best meet the needs of all of our members.

Abstracts in response to Call for Papers are submitted through AACAP’s online system and the deadline is usually February 15th. On February 16th, staff begins the process of making sure all the submissions are complete. We then go through the process of assigning the submissions for review. This stage usually takes several weeks with the goal of getting submissions to the Program Committee reviewers by March 1st.

By necessity, the Program Committee is made up of a diverse group of dedicated members with varying areas of expertise who come together each year in April to build a program that we can be proud of and that will help improve our sub-specialty. At least three Program Committee members review every submission, and then work as a team to make a recommendation to accept, reject, or discuss the submission with the full committee. In addition, the Program chair and deputy chair review all 700-plus submissions to get a “big picture” of the program to ensure it provides the balance we feel is necessary. This is a very time-consuming process. Every submission needs to be reviewed in advance in order for staff to get every reviewer’s ratings and comments online for the April program committee meeting. Each reviewer then reviews the scores and comments of the other members of his/her team, and the team then makes the initial recommendation. During the April review process, the committee discusses everything from research design and methods to clinical applicability to presenter composition for every single submission. Finally, the Program chair’s job is somewhat like that of a journal editor whose goal is to shape the program to create the best meeting possible. That sometimes means changing the form of the submissions, e.g., if we think something works better as a clinical case conference rather than a breakfast, we will suggest that. If we feel the program is lacking a particular topic, we might work with the submitters to further shape their contribution. However, there needs to be substance and detail in the submission in order for us to do that. A promissory note of what you hope to do by October is not acceptable. Being famous is not enough. Unfortunately, however, unlike a journal editor, we do not have the time to provide critiques to those who have submitted abstracts.

Ways to Improve Your Annual Meeting Submission

In closing, here are some tips as you prepare your submissions for the February 15th Call for Papers deadline:

- Review the various types of programs offered at the Annual Meeting and match your topic and learning objectives that best fit the format.
- Identify speakers who provide diverse perspectives on your topic to present a balanced program.
- For Symposia and Clinical Perspectives, consider using a discussant to pull together different points of view on the topic.
- Provide sufficient detail in the Review Abstract so that we can fully understand the goals and methods of your presentation.
- Clearly state the learning objectives and practice gap; these are used to determine the optimal balance for the program.

If you are unsure about your topic or how to put the program together, please e-mail me with details of your ideas (Gabrielle. Carlson@stonybrookmedicine.edu). The Program Committee and I are happy to give you feedback and suggestions for improvement to make it a high-quality submission. But remember, the Call for Papers deadline is February 15th, so please start developing your ideas now. Do not wait until the last minute! We look forward to receiving your submissions and partnering with you to make our Annual Meeting the best it can be!

The next article in this series explains the way that we put together the Annual Meeting schedule and the logistics involved in this process.

OCTOBER 23-28, 2012 • SAN FRANCISCO, CA
Repairing the Effects of Early Trauma

Robert L. Hendren, D.O.

The objective of Clinical Practicum at the AACAP 59th Annual Meeting was to have attendees learn about the biological and mental health sequelae of trauma exposure in infancy and early childhood, and the key elements of evidence-based treatment for traumatized children in the birth-to-five age range. The day-long Practicum took place at the San Francisco General Hospital (affiliated with the University of California, San Francisco - UCSF) where the Child Trauma Research Program (CTRP) is located. The CTRP developed and laid the empirical foundations for the efficacy of Child-Parent Psychotherapy (CPP), an evidence-based treatment for traumatized young children and their parents. Dr. Hendren then described the CTRP and explained CCP. An ecological model of developmental outcome in child functioning is shaped by the interplay of risk and protective factors within the child and in the environment. Risk factors co-exist and compound each other, generate secondary stresses, and exist on a continuum from stress to trauma. The treatment target of CPP is to create a system of jointly constructed meanings in the child-parent relationship. These meanings emerge from each partner's representations of themselves and each other. Mental representations are expressed through individual or interactive language, behavior, and play. Therapeutic strategies to foster mutual understanding include: translating the parent's and child's meanings to each other; promoting protectiveness, empathy, trust, and pleasure; finding the positive and reframing the negative; showing that love helps to tolerate ambivalence; instilling hope by giving meaning to trauma; and fostering pleasure in daily pursuits.

Assessment, formulation, and treatment planning was then concisely and movingly reviewed by Dr. Van Horn. Domains of assessment include the trauma history of both parent and child; the parent's awareness of her own and the child's trauma response; symptoms and behavior problems; and the quality of the parent-child relationship. The formulation puts together the problems/strengths identified and symptoms of disorder in parent and child. Treatment planning is collaborative and starts with an agreement about what the child will be told about the treatment. Treatment goals include dyadic regulation, accepting and naming feelings, understanding the source of feeling, coping with feeling, the parent's and child's ability to find pleasure in one another, and the parent's and child's ability to find benign meanings in one another's behavior.

Chandra Ghosh Ippen, Ph.D., Associate Research Director at the CTRP, presented An Integrative Framework for Enhancing Trauma-informed Practice. Core to this presentation is the rationale for why, across systems, we need to think about and understand trauma. The presentation began with a description of the importance of the National Child Traumatic Stress Network in disseminating information regarding trauma-informed practices. Then an integrative framework for understanding trauma and enhancing trauma-informed practice was presented. The basis of this framework was then discussed including definitions, prevalence, complexity, effects on functioning, and consequences. Many illustrations of how the framework helps us understand the effects of trauma were provided along with how trauma affects functioning, and why individuals may respond differently in response to a traumatic event. A model for an interconnected web of trauma responses was the basis for discussion of how trauma affects the caregiver, the family, the provider, the community, and the culture. The model includes an integrative lens that shows how key factors including development, culture and context, history, and systems affect perspective and the work. Discussion connected concepts to practice implications across systems linking, guiding theoretical concepts to goals of intervention and desired outcomes, critical elements of practice, and therapeutic skill in implementing interventions.

“For example, a study was presented demonstrating how changes in children’s stress reactivity may be a mechanism for socioeconomic status (SES) effects on child health.”
The final presentation from Nicole Bush, Ph.D., assistant professor of Psychiatry at UCSF was Neurobiologic Embedding of Early Life Stress and Biological Moderators of Intervention Effects. It began with a conceptual framework based on the bioecological model of Bronfenbrenner, with developmental life course influences, including neurogenomics and Hypothalamic-Pituitary-Adrenal Axis (HPA) stress regulation and reactivity. This led to a review of evidence for biological embedding of early-life stress. For example, a study was presented demonstrating how changes in children’s stress reactivity may be a mechanism for socioeconomic status (SES) effects on child health. Changes such as muted sympathetic reactivity and excessive glucocorticoid arousal over time can lead to damaged bodily tissues and compensatory activity in other systems and disorders (e.g., allostatic load). Dr. Bush also reviewed the ways in which telomere shortening related to child trauma, chronic stress, PTSD, and threat; and how these associations point to ways to potentially improve telomere length through lifestyle changes. The later part of the presentation and discussion focused on how we might identify who needs intervention and for whom intervention is most effective; a review of evidence for biological moderators of intervention effects including genetic and epigenetic variation; and in conclusion, the application of this neurobiologic model to CPP.

The CPP model derives its theoretical base from Selma Fraiberg’s “ghosts in the nursery” psychoanalytic model of inter-generational transmission of psychopathology, John Bowlby and Mary Ainsworth’s attachment theory, research-based theoretical models of developmental psychopathology and trauma developed by Michael Rutter, M.D., Dante Cicchetti, and Robert Pynoos, M.D., among others, and community-based knowledge of the influence of cultural values and practices on child and family functioning. In keeping with the community mental health mission of the San Francisco General Hospital Department of Psychiatry, CTRP focuses on the application of CPP to low-income children with a high representation of underserved minorities and immigrant families, the dissemination of CPP to community-based agencies, and the application of early trauma principles to create trauma-informed systems of care. Since 2001, the program has been a center of the federally funded National Child Traumatic Stress Network, a SAMHSA initiative with the goal of increasing access to services and raising the standard of care for children, families, and communities across the country. CPP is being disseminated nationally and internationally through 18-month-long, face-to-face and long-distance learning collaboratives and other formats for long-distance training.

Dr. Hendren is past-president of AACAP. He is director of Child and Adolescent Psychiatry and vice chair of the Department of Psychiatry at the University of California San Francisco. He may be reached at Robert.Hendren@ucsf.edu.
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Contact AACAP Member Services at 202.966.7300, ext. 2004 or by e-mailing membership@aacap.org with your colleague’s contact information.

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.

In Memoriam

Joseph Martin Green, M.D.

Joseph Martin Green, M.D., passed away on October 5, 2012, at the age of 87 following complications of cardiac valve replacement surgery. He was the Chief of Child Psychiatry at the University of Wisconsin, Madison, and chair of the child and adolescent psychiatry certification committee of the American Board of Psychiatry and Neurology. He also served as the president of the Arizona and Wisconsin Psychiatric Associations, and mentored numerous child psychiatrists. He retired in 1988, and enjoyed reading, opera, nature walks, and playing bridge or cribbage with friends and family.
Child and adolescent psychiatrists can extend their reach and educate a wide audience by working with the news media. The AACAP Communications Office connects journalists with AACAP members. If you would like to work with the news media, please contact the Communications Office with your area of interest at Communications@aacap.org.

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

- **Stephen Cozza, M.D.**, was quoted in a story with the American Forces Press Service about children and 9/11. The article, “Parents Should Stress Safety at 9/11 Anniversary,” was posted on September 8, 2012.
- **Craigan Usher, M.D.**, spoke with a reporter for The Oregonian about perfectionism in children. The article, “Perfectionist Kids and How to Handle Them,” appeared on September 13, 2012.
- **Harold Koplewicz, M.D.**, was interviewed by The Wall Street Journal about prescribing medication to children. The article, “Are ADHD Medications Overprescribed?” was posted on September 14, 2012.
- **Laura Prager, M.D.**, wrote an article for The Boston Globe about mental health emergencies. The article, “Some Emergencies Need More than the Emergency Room,” was published on October 2, 2012.
- **James Margolis, M.D.**, wrote a letter to the editor to The Sacramento Bee on ADHD medications. The article, “Prescriptions Can Help Many Kids with ADHD,” was published on October 10, 2012.
- **Nancy Rappaport, M.D.**, was quoted in an article for The New York Times, titled “Attention Disorder or Not, Children Prescribed Pills to Help in School,” on October 9, 2012. Dr. Rappaport also responded to an article by The New York Times with a blog post in The Huffington Post. The blog post, “The Art of ADHD: Can We Free Children from ‘Chemical Straitjackets?’” was posted on October 12, 2012.
- **Ellen Leibenluft, M.D.**, and Charles Zeanah, M.D., were interviewed by The Wall Street Journal about mental illness in children. The article, “The Long Battle to Rethink Mental Illness in Children,” was posted on October 18, 2012.
- **David Axelson, M.D.**, was quoted by Clinical Psychiatry News discussing pediatric bipolar disorder. The article, “Don’t Overreach for Subthreshold Pediatric Bipolar Disorder,” appeared on November 5, 2012.
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AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, advocacy, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. Thank you to the following donors for their generous financial support of our mission.

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JANUARY/FEBRUARY 2013
Back to Project Future
Defining the coming decade
www.aacap.org

We’re Fired Up and Rolling!

James C. Maclntyre, II, M.D.,
Chair, Back to Project Future

What Has Happened So Far?
On Monday afternoon, October 22, 2012, as the Annual Meeting was starting in San Francisco, the Steering Committee of Back to Project Future came together to continue their collective brainstorming and discussions about the future of child and adolescent psychiatry in the coming decade. They had started this journey in April at the AACAP offices in Washington, D.C. The ten members of the BPF Steering Committee come from different parts of the country and represent diverse areas of practice and experience.

Back to Project Future, one of Martin J. Drell, M.D.’s Presidential Initiatives, provides a time-limited process to develop a 10-year action plan (2013-2023) for AACAP and the field of child and adolescent psychiatry. Back to Project Future will produce a set of prioritized goals, recommendations, and action steps that can help guide AACAP’s leadership and members as they face many changing clinical, training, research, and social/economic realities in the coming decade.

During the 2012 Annual Meeting, all Back to Project Future participants wore special red ribbons to identify them and facilitate dialogue and discussion with AACAP members. The San Francisco meeting was a time to listen and gather ideas and questions and concerns from the membership. Other BPF activities at the meeting included a special 90 minute BPF Town Meeting; brief presentations at the Assembly of Regional Organizations of Child and Adolescent Psychiatry and AACAP Council; and an update for all AACAP committee chairpersons. In addition, members of the BPF leadership group (David Pruitt, M.D., Neal Ryan, M.D., Michael Houston, M.D., and Richard Martini, M.D.) participated in numerous AACAP committee meetings as they discussed Back to Project Future.

So What’s Next?
The Back to Project Future Steering Committee and subgroups will create the first draft of a final report and then work diligently to prioritize and refine the different recommendations and action steps into a workable plan. Throughout this phase, the Back to Project Future...
leadership and the three subgroups will continue to interact with many AACAP committees and a group of distinguished consultants to revise and improve the draft plan. Ultimately, the finished report of Back to Project Future will be presented to Dr. Drell in September 2013.

Back to Project Future wants to hear from you! We need to hear members’ ideas, questions, and concerns about the future of child and adolescent psychiatry in the coming decade. You can stay informed about Back to Project Future by going to our webpage on the “Members Only” section of the AACAP website. You should also look for e-mails from AACAP with information about the project. Please contact any of the leadership group: Dr. MacIntyre, chairperson of Back to Project Future; Dr. Pruitt, Training and Workforce subgroup; Dr. Ryan, Research subgroup; and Drs. Martini and Houston, Service/Clinical Practice subgroup. You can also send any questions and ideas to our special e-mail address: bpfquest@aacap.org.

Dr. MacIntyre is chairperson of the Steering Committee for Back to Project Future. He has been Secretary and Treasurer for AACAP and served on Council and in the Assembly as an officer and delegate. He was also chairperson of the AACAP Consumer Issues Work Group. Dr. MacIntyre works full-time as an attending child and adolescent psychiatrist for Carolinas HealthCare System (a non-profit system) in Charlotte, North Carolina.
AACAP
Mentorship Network

Be part of a network of enthusiastic AACAP members committed to mentoring medical students, residents & early career psychiatrists.

The Mentorship Network aims to:

• Identify, recruit & provide quality mentors to medical students, residents & early career psychiatrists interested in child and adolescent psychiatry;

• Introduce mentors & mentees;

• Recruit medical students & residents into child and adolescent psychiatry; and

• Enhance careers & build relationships between mentors and mentees.

Make a difference in the careers of medical students, residents or early career psychiatrists by serving as a mentor.

Contact:
AACAP Research, Training, and Education Department
(202) 966-7300 • training@aacap.org
ASSOCIATE PSYCHIATRIST-IN-CHIEF AND VICE CHAIRMAN OF PSYCHIATRY

Boston Children’s Hospital

Boston Children’s Hospital, Harvard Medical School in Boston, Massachusetts, is seeking an Associate Psychiatrist-in-Chief and Vice Chairman of Psychiatry. With over 140 faculty members (42 psychiatrists and 104 psychologists), the Department of Psychiatry’s active and diverse programs in clinical services, education, and research encompass all aspects of the field of child and adolescent psychiatry. The Department’s clinical programs provide approximately 14,500 outpatient visits, 800 medical consultations, 1,000 emergency room consultations, and 200 inpatient admissions, and serve 3,000 students in the community every year. The Department’s Program for Behavioral Science promotes healthy brain development through research excellence and innovation. For more than 50 years, the Department has offered excellent and highly sought after training programs in child psychiatry, psychology, and social work. Excellent skills in clinical and educational administration, academic productivity, demonstrated leadership abilities, and mentorship interests are sought for this position. A strong collaborative nature will be required to sustain and build partnerships both within and outside the hospital setting. The candidate for this position must be board certified in child and adolescent psychiatry. The proposed position will be at either the rank of Professor or Associate Professor at Harvard Medical School.

Letter of application detailing relevant experience and a recent curriculum vitae should be sent to the attention of:

David R. DeMaso, M.D.
Psychiatrist-in-Chief and Chairman of Psychiatry
Department of Psychiatry, Boston Children’s Hospital
300 Longwood Avenue
Boston, MA 02115

Or to:
david.demaso@childrens.harvard.edu
Boston Children’s Hospital

The Department is seeking enhanced administrative leadership from a gifted mid-to-senior level academic child psychiatrist with scholarly strengths across clinical and teaching domains. This position will help build the capacity of the Department to respond to the increased demands for behavioral health services and training in the context of national healthcare reform.

Women and minorities are encouraged to apply.

ADDITIONS CHILD AND ADOLESCENT PSYCHIATRIST

Boston Children’s Hospital

The Division of Developmental Medicine in the Department of Medicine and the Department of Psychiatry at Boston Children’s Hospital are offering a full-time opportunity for a child and adolescent psychiatrist in its innovative Adolescent Substance Abuse Program (ASAP) and the Developmental Medicine Center (DMC). The ASAP program provides national leadership in the identification, diagnosis, and treatment of substance use and disorders in children and adolescents. This interdisciplinary program offers comprehensive evaluations, counseling, group treatment, parental guidance, psychopharmacology, and medication supported recovery for opioid and alcohol dependence. The DMC is one of the largest clinical programs for the diagnosis and treatment of developmental disorders in the U.S., and is involved in clinical care and research as well as the training of pediatricians and psychologists. We are looking for a psychiatrist not just interested in prescribing medicine, but one wanting to join an exciting scholarly program to provide integrated healthcare services. The ideal candidate will have board eligibility or certification in Child Psychiatry or experience in addictions medicine. This position will include an appointment at Harvard Medical School.

Letter of application detailing relevant experience and a recent curriculum vitae should be sent to the attention of:

Sandra Maislen
Administrative Director
Division of Developmental Medicine
Boston Children’s Hospital
300 Longwood Avenue, Fegan 10
Boston, MA 02115

Women and minorities are encouraged to apply. Boston Children’s Hospital is an Affirmative Action/Equal Opportunity Employer.

NEW YORK

CHILD AND ADOLESCENT PSYCHIATRIST

Erie County Medical Center

J1 Visa Waiver Available for Qualified Applicant

Work as Attending Psychiatrist in the Comprehensive Psychiatric Emergency Program (CPEP) at the Erie County Medical Center (ECMC) in Buffalo, New York, with a faculty appointment in the Department of Psychiatry at the State University of New York at Buffalo (SUNYAB).

Responsibilities and Duties:

1. Clinical: Perform diagnostic evaluations, provide acute treatment services, and implement appropriate treatment dispositions for adults, children, and adolescents presenting for care in CPEP.

2. Interdisciplinary Collaboration: Work cooperatively with hospital and university administrators, community agencies, and public relations staff at both ECMC and SUNYAB; interact synergistically with other SUNYAB faculty, nurses, and paramedical staff.

3. Teaching: Supervise activities and provide constructive feedback to psychiatry residents, medical students, and other trainees assigned to CPEP.
Work along with other attending psychiatrists and hospital staff to provide direct clinical services to patients in the Psychiatric Emergency Department at ECMC and participate fully as a member of the clinical faculty in the Department of Psychiatry, SUNYAB.

Professional Requirements and Opportunities:

1. Education and Certification: M.D. or D.O. with completion of residency training in both general and child/adolescent psychiatry; licensed or eligible for licensure in New York State; board eligible or board certified in both general and child psychiatry (if not board certified at time of hire, must complete board certification within four years of appointment or have specific approval from the Chairman of the Department of Psychiatry for contract renewal).

2. Skills/Abilities: Competence in psychiatric diagnostic evaluation and interdisciplinary treatment planning for adults, adolescents, and children; competence in psychopharmacological interventions; good interpersonal skills; fluency in working with a multidisciplinary treatment team.

3. Academic Advancement: Clinical and scholarly mentoring to support faculty members’ academic development; participation in clinical research activities.

4. Clinical: Develop supplementary private practice within the University Psychiatric Practice (UPP); moonlight in departmentally approved clinical sites and facilities.

We are an equal opportunity/affirmative action employer. Compensation and benefits for this position are in accord with parity and commensurate with experience.

Contact:
Bruce D. Miller, M.D., Chief
Child and Adolescent Psychiatry
State University of New York at Buffalo
Phone: (716) 878-7645
Fax: (716) 888-3935
E-mail: brumill@buffalo.edu

CHILD AND ADOLESCENT PSYCHIATRIST

Saratoga Hospital
Saratoga Hospital seeks a Child and Adolescent Psychiatrist to join our close-knit, experienced multi-disciplinary care team at the Saratoga County Mental Health Clinic in Saratoga Springs, NY. This part-time outpatient opportunity, offering negotiable hours, provides flexibility for those practicing in the private sector or wishing to do so in the region. Psychiatrists can take optional call for additional compensation for the hospital’s 16-bed adult inpatient mental health unit. The compensation package for this position will be competitive.

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Contact:
Denise Romand
Medical Staff Recruiter
Phone: 518-83-8465
docfind@saratogacare.org

Learn more about us:
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Lehman Valley Health Network

Lehman Valley Health Network (LVHN) is expanding its well-established child and adolescent psychiatry service, which includes three psychiatrists. Our psychiatrists manage our 13-bed inpatient adolescent unit, see patients in the office, and also do consults. We have a children’s ER, new pediatric residency, and supportive network that fosters individual interests. At LVHN we have a great continuum of care in behavioral health from emergency evaluation, inpatient care, partial hospitalization, and outpatient care. We are offering a competitive salary and outstanding benefits. We are seeking a collaborative, board certified or eligible child and adolescent psychiatrist with strong clinical and interpersonal skills. LVHN is a fiscally strong, high performing health network which includes three hospital campuses in the neighboring cities of Allentown and Bethlehem, a large multispecialty physician groups and nine health centers. We are located in a beautiful suburban area known as the Lehigh Valley, which is only 1 hour north of Philadelphia and 1.5 hours west of New York City.

Interested physicians should e-mail a CV to:
Michael Kaufmann, M.D.
Chair of Psychiatry
c/o tammy.jamison@LVHN.org
or call (610) 969-0207 for more information.

Pennsylvania

CHILD AND ADOLESCENT PSYCHIATRIST

Lehman Valley Health Network
Lehman Valley Health Network (LVHN) is expanding its well-established child and adolescent psychiatry service, which includes three psychiatrists. Our psychiatrists manage our 13-bed inpatient adolescent unit, see patients in the office, and also do consults. We have a children’s ER, new pediatric residency, and supportive network that fosters individual interests. At LVHN we have a great continuum of care in behavioral health from emergency evaluation, inpatient care, partial hospitalization, and outpatient care. We are offering a competitive salary and outstanding benefits. We are seeking a collaborative, board certified or eligible child and adolescent psychiatrist with strong clinical and interpersonal skills. LVHN is a fiscally strong, high performing health network which includes three hospital campuses in the neighboring cities of Allentown and Bethlehem, a large multispecialty physician groups and nine health centers. We are located in a beautiful suburban area known as the Lehigh Valley, which is only 1 hour north of Philadelphia and 1.5 hours west of New York City.

Interested physicians should e-mail a CV to:
Michael Kaufmann, M.D.
Chair of Psychiatry
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WARNINGS AND PRECAUTIONS

Hypotension/Bradyarrhythmia

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 -4.0 mmHg on KAPVAY 0.2 mg/day and -8.3 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in diastolic blood pressure was -4.0 mmHg on KAPVAY 0.2 mg/day and -7.3 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in heart rate was -4.0 beats per minute on KAPVAY 0.2 mg/day and -7.7 beats per minute on KAPVAY 0.4 mg/day. During the taper period of the fixed-dose monotherapy study the maximum placebo-subtracted mean change in systolic blood pressure was +3.4 mmHg on KAPVAY 0.2 mg/day and -5.6 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in diastolic blood pressure was +3.3 mmHg on KAPVAY 0.2 mg/day and -6.5 mmHg on KAPVAY 0.4 mg/day. The maximum placebo-subtracted mean change in heart rate was -0.6 beats per minute on KAPVAY 0.2 mg/day and -3.0 beats per minute on KAPVAY 0.4 mg/day.

Measure heart rate and blood pressure prior to initiation of therapy; following dose increases, and periodically while on therapy. Use KAPVAY with caution in patients with a history of hypotension, heart block, bradycardia, or cardiovascular disease, because it can decrease blood pressure and heart rate. Use caution in treating patients who have a history of syncope or may have a condition that predisposes them to syncope, such as hypotension, orthostatic hypotension, bradycardia, or dehydration. Use KAPVAY with caution in patients treated concomitantly with antiarrhythmics 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

Somnolence and sedation 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 flexible dose pediatric additive to stimulants study, 19% of patients treated with KAPVAY+stimulant vs 8% treated with placebo+stimulant reported somnolence. Before starting KAPVAY with other centrally active depressants (such as phe- nothiazines, 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 every 3 to 7 days until treatment is discontinued. 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, tightness in chest, and anxiety. In adults with hypertension, sudden cessation of treatment with immediate-release clonidine has, in some cases, resulted in symptoms such as nervousness, agitation, headache, and tremor accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma.

Allergic Reactions

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

ADVERSE REACTIONS

Clinical Trial Experience

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

Study 1: Fixed-dose KAPVAY Monotherapy

Study 1 was a multi-center, randomized, double-blind, placebo-controlled study with primary efficacy endpoint at 5 weeks, of two fixed doses (0.2 mg/day or 0.4 mg/day) of KAPVAY in children and adolescents (6 to 17 years of age) who met DSM-IV criteria for ADHD hyperactive or combined 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>KAPVAY 0.4 mg/day (N=76)</td>
<td></td>
</tr>
<tr>
<td>KAPVAY 0.2 mg/day (N=76)</td>
<td></td>
</tr>
<tr>
<td>Placebo (N=76)</td>
<td></td>
</tr>
<tr>
<td>Somnolence</td>
<td>31%</td>
</tr>
<tr>
<td>Headache</td>
<td>19%</td>
</tr>
<tr>
<td>Upper Abdominal Pain</td>
<td>13%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>13%</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>6%</td>
</tr>
<tr>
<td>Irritability</td>
<td>6%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>6%</td>
</tr>
<tr>
<td>Nausea</td>
<td>6%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>5%</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>5%</td>
</tr>
<tr>
<td>Gastrointestinal Vomiting</td>
<td>5%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>5%</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>3%</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 like Illness</td>
<td>3%</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>3%</td>
</tr>
<tr>
<td>Tension</td>
<td>3%</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>3%</td>
</tr>
<tr>
<td>Lower Respiratory Tract Infection</td>
<td>0%</td>
</tr>
<tr>
<td>Polyuria</td>
<td>0%</td>
</tr>
<tr>
<td>Sleep Change</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Percentage of Patients Reporting Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>KAPVAY 0.4 mg/day (N=76)</td>
<td></td>
</tr>
<tr>
<td>KAPVAY 0.2 mg/day (N=76)</td>
<td></td>
</tr>
<tr>
<td>Placebo (N=76)</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>Otalgia Medica Acute</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

Commonly observed adverse reactions (incidence of ≥2% in either active treatment group and greater than the rate on placebo) during the taper period are listed in Table 3.
Study 2: Flexible-dose KAPVAY as Adjunctive Therapy to Psychostimulants

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

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

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

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>KAPVAY+STM (N=102)</th>
<th>PB0+STM (N=96)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somnolence</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>16%</td>
<td>4%</td>
</tr>
<tr>
<td>Abdominal Pain Upper</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Nasal Congestion</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Decreased Appetite</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Body Temperature Increased</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Epileptics</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Pain in Extremity</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>KAPVAY+STM (N=102)</th>
<th>PB0+STM (N=96)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Congestion</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Headache</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Irritability</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Throat Pain</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Gastroenteritis Veral</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Rash</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

1. Taper Period: weeks 6-8

Most common adverse reactions, defined as events that were reported in at least 5% of drug-treated patients and at least twice the rate in 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 somnolence/sedation (5%) and fatigue (4%). Less common adverse reactions leading to discontinuation (occurring in approximately 1% of patients) included: vomiting, prolonged QT, increased heart rate, and rash. In the pediatric adjunctive treatment to stimulants study, one patient discontinued from KAPVAY + stimulant group because of bradycardia.

Effects on Laboratory Tests, Vital Signs, and Electrocardiograms

KAPVAY treatment was not associated with any clinically important effects on any laboratory parameters in either of the placebo-controlled studies. Mean decreases in blood pressure and heart rate were seen [see Warnings and Precautions (5.1) in the full prescribing information]. There were no changes on ECG 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-depressive effects of alcohol, barbiturates or other sedating drugs.

Interactions with Tricyclic Antidepressants

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

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

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

Use with other products containing clonidine

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

Antihypertensive Drugs

Use caution when KAPVAY is administered concomitantly with antihypertensive drugs, due to the potential for additive pharmacodynamic effects (e.g., hypotension, syncope) [see Warnings and Precautions (5.2) 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 for 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 praputial separation was seen in males treated with the highest dose (with a no-effect dose of 160 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 reversible 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.

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Last modified 01/2012
Add KAPVAY® to a stimulant—
achieve significant symptom improvement1,2

- In the add-on trial, KAPVAY® demonstrated efficacy at week 5 (primary end point as measured by the ADHD RS-IV Total Score) with statistically significant symptom improvement seen as early as week 2.1,2

Offer convenient flexibility to your patients

- KAPVAY® can be administered with or without food3
- When KAPVAY® is added to a stimulant, the dose of the stimulant can be adjusted/reduced depending on the patient’s response3

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-depressant 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., digitals, 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.


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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 website. Only screened advertisers and recruiters have access.

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