AACAP held its sixth annual Advocacy Days activities on May 6-7, 2010, in Washington, D.C., with over 160 participants, including child and adolescent psychiatrists, residents, and family advocates. With support from AACAP’s Campaign for America’s Kids, AACAP worked with Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), the Child and Adolescent Bipolar Foundation, the Federation of Families for Children’s Mental Health, Mental Health America, and the National Alliance on Mental Illness to bring 44 parents and youth to Washington, D.C., to participate in this year’s events. We were also joined by the CHADD Board of Directors, who planned their annual meeting to accompany Advocacy Days.

This year featured the debut of an expanded format, including a 2-hour session on May 6th entitled “Advocacy Training: How to be a Better Advocate.” This program was created to help attendees better understand the legislative process and advocacy techniques. Participants were armed with tools to continue their advocacy efforts beyond Advocacy Days, including how to plan their message, reach out to the media, and partner with AACAP. Following the training presentation, the attendees worked together to practice their advocacy techniques and polish their messages for their Congressional meetings.
Plan your trip to New York TODAY! Full program details and hotel and travel information are online at www.aacap.org/cs/AnnualMeeting/2010. Registration for AACAP members ONLY opens August 2, 2010.
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**MISSION**

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

**FUNCTIONS AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY**

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

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

**MISSION OF THE AACAP NEWS**

The mission of the AACAP News includes: (1) Communication among AACAP members, components, and leadership. (2) Education regarding child and adolescent psychiatry. (3) Recording the history of AACAP. (4) Artistic and creative expression of AACAP members. (5) Provide information regarding upcoming AACAP events. (6) Provide a recruitment tool.

That seems like a long time ago. Do you know what else happened in 2002? Dr. Marilyn Benoit, M.D., was the AACAP president. AACAP was preparing for its 50th anniversary celebration at the Annual Meeting in Miami in 2003. Also, that was the last time we raised our membership dues. The annual dues for general members had been $295 from 1996 to 2002. They have been $350 from 2002 until the present. When 2011 arrives, that will be nine years without a dues increase, which is quite an accomplishment. Between 2002 and the present, the Consumer Price Index has gone up about 19 percent.

Take a moment to think about the achievements of AACAP since 2002. Since that time, AACAP has grown impressively in our services and products, which are available to members as well as the general public. Since 2002, our members and staff have developed and published 17 practice parameters, ranging from Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions (2002) to the Use of Psychotropic Medication in Children and Adolescents (2009). The Lifelong Learning Modules were introduced in 2005, and since then we have sold almost 4,000 modules. Our advocacy efforts, through our Department of Government Affairs and Clinical Practice, helped bring about the passage of the Mental Health Parity Act in 2008 and, more recently, the creation of a new loan repayment program for child and adolescent psychiatry residents with the healthcare reform legislation. Our Advocacy Days each spring have become important annual events on Capitol Hill, when our members can meet with their elected officials to discuss how legislation will affect our profession and our patients.

In 2007, eAACAP was introduced, which now features an array of Resource Centers, including Oppositional-Defiant Disorder, Disaster and Trauma, Depression, Conduct Disorder, Bipolar Disorder, Autism, and Anxiety Disorders. We will soon have one hundred Facts for Families on-line. In 2009, we launched the AACAP Facebook page – primarily directed toward medical students and residents – and we have more than 1,200 friends. Our annual meetings are remarkable for their size (now averaging about 4,000 registrants), their international representation (about 55 countries), and their scientific content. The Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP) has excelled, in some years achieving the highest impact factor among all professional journals that relate to pediatric medicine. In February 2010, JAACAP published its first article that can be used for continuing medical education. Through these past and recent successes, our organization has given members tremendous value for the dues and fees that have been charged. Finally, the current presidential initiative, spearheaded by President Laurence Greenhill, M.D., Project AACAP, has already introduced small and large changes to enhance the membership experience: improving the Members’ Only section of our Web site, such as including the charge and the annual report for every component; arranging for automated payment of quarterly dues by credit card; and creating the Web Editorial Board, a new component that will function as editors of our entire Web site.

During the recession of 2008-09, our long-term investments lost value, and now they are recovering. Thanks to the diligence and foresight of earlier Executive Committees and Councils, we enjoyed financial stability during that time. For example, we had financial reserves to fall back on and we own our headquarters building, which is worth about $5,000,000. Unlike other organizations and institutions, we did not have to curtail staffing, services, or member benefits in any significant manner. Each generation benefits from the prudent stewardship of those who came before.

However, the AACAP Executive Committee and the Council do have financial concerns. It is our goal that our revenue from day-to-day operations exceed our expenses – in other words, that we have a balanced budget. In

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Attendees put their training into action on May 7, when they met with over 150 Congressional offices, representing 35 states. Kristin Kroeger Ptakowski, AACAP’s senior deputy executive director and director of government affairs and clinical practice, emphasized that “even though Congress recently passed healthcare reform, the work to improve mental healthcare for children and adolescents is never done.”

In their meetings, the advocates related their personal experiences as psychiatrists, family members, and patients. The issues they discussed covered five areas: 1) prevention and access to child psychiatric services, 2) school-based mental health, 3) funding for child and adolescent mental health research and services, 4) juvenile justice reform, and 5) behavioral health information technology. Participants asked the congressional offices to support several bills, including The Child Healthcare Crisis Relief Act (H.R. 1932/S. 999), The Mental Health in Schools Act of 2009 (H.R. 2531), The Juvenile Justice and Delinquency Prevention Act (S. 678), and The Health Information Technology Extension for Behavioral Health Services Act of 2010 (H.R. 5040).

AACAP hosted a luncheon and briefing for Advocacy Days participants and Congressional staffers. The briefing, Children and Families of Combat Veterans, featured AACAP member Stephen Cozza, M.D., associate director of the Center for the Study of Traumatic Stress at the Uniformed Services University. During the luncheon, Ms. Kroeger Ptakowski presented Tamar Magarik Haro and Jeremy Sharp with the Friends of Children’s Mental Health Congressional Staff Award for their work with Senator Christopher Dodd of Connecticut on the Health, Education, Labor, and Pensions Committee. Their work has provided children’s healthcare, and child and adolescent psychiatry specifically, with meaningful legislative and public awareness efforts.

AACAP also honored two members of Congress for their dedication to children’s mental health issues on May 6. AACAP President Laurence L. Greenhill, M.D., and Peter Geier, M.D., presented Senator Sherrod Brown of Ohio and Representative Robert C. “Bobby” Scott of Richmond, Virginia,
with the Friends of Children’s Mental Health Award. Senator Brown was recognized for his extraordinary leadership in ensuring that child and adolescent psychiatry residents received loan repayment as part of the national healthcare reform act. Representative Scott was lauded for his juvenile justice reform efforts, specifically his ardent support of The Youth PROMISE Act and commitment to reducing gang violence and crime.

Following the visits on Capitol Hill, many attendees met to discuss their experiences, reporting that the offices and staff members were very receptive to the call for increased access and improved services for children with mental illness. Debra Koss, M.D., of New Jersey noted that she has met with the same staff members for several years in a row, and has found that it is important to come to Advocacy Days every year to demonstrate the persistence of child mental health advocates. Dr. Koss encouraged members to utilize their training and advocate back home in their states and communities. Several members also reported that they invited the Congressional staffers and legislators to tour their hospitals and learn about the issues firsthand.

AACAP members found the parents and youth to be especially powerful advocates in the Congressional meetings. One of those families was Paul and Loy McGill, parents of 11-year-old Duncan McGill, from North Carolina. Loy McGill noted that having families and youth at the meetings gives a face to mental illness. She explained that raising a child with mental illness is a “lifetime journey. We need [legislators] to help us chart the course for our nation’s children.”

Advocacy Days also coincided with National Children’s Mental Health Awareness Day on May 6. Led by the Substance Abuse and Mental Health Services Administration (SAMHSA), Awareness Day promotes positive youth development, resilience, and recovery. This year’s events focused on early childhood mental health. SAMHSA hosted the Awareness Day Early Childhood Forum, co-sponsored by AACAP, which consisted of two panels. The first panel was on positive social and emotional development, and the second discussed “what to do when problems arise” and featured Albert Zachik, M.D.

AACAP is already looking forward to Advocacy Days 2011. We encourage all AACAP members who want to influence mental health policy, improve the lives of their patients, and advocate for the profession to become involved throughout the year. Visit our Web site at http://www.aacap.org/cs/advocacy to stay up to date on AACAP’s advocacy efforts, download resources, and learn more about Advocacy Days 2011!

Kristin Kroeger Ptakowski, Laurence Greenhill, M.D., and Peter Geier, M.D., present Senator Sherrod Brown (OH.) with AACAP’s Friends of Children’s Mental Health Award.
The saying “if it’s too good to be true, it’s too good to be true” kept flitting through my mind.
Louis Kraus, M.D.

Joe Sullivan was arrested in 1989 at the age of 13 years. After a one-day trial, he was found guilty. His crime? He had robbed and raped a 72-year-old woman. At the time of his arrest, he already had been in trouble for burglary, assault, and for killing a dog. He was sentenced to life in prison without the possibility of parole. Twenty years later, in November 2009, the Supreme Court heard arguments in his case (Sullivan v. Florida), and another youth (Graham v. Florida), to decide whether juvenile life imprisonment without parole (JLWOP) is constitutional.

Years of research validate what every parent knows: Children's brains are different than adult brains. Children react differently to stress, they react differently to changes in their environment, they are more impulsive, and they have relative deficits, in certain circumstances, in looking at short and long-term ramifications of their behaviors.

In the 1960s, research began to identify areas of the brain that appeared to show significant growth and change throughout adolescence and into early adulthood (Fassler and Harper 2007) (Yakovlev and Lecours 1967). More recently, the work of Jay Giedd (2008) on mapping the cerebral cortex using neuroimaging techniques has provided essential information about the differences between the developing and the mature brain. Giedd expresses concern over early interpretation of the data but at the same time states, “Imaging modalities are beginning to elucidate the implications of these brain changes on cognition, emotion, and behavior.”

It is common knowledge that teenagers tend to be more impulsive than adults. Functional MRI and neuroimaging studies allow us to understand the ongoing pruning and myelination between the frontal lobe and midbrain that helps explain this phenomenon. There are no neuroimaging studies at the present time to show a causal relationship between brain development and these behaviors. At the same time, there is enough correlational data present in this research that states no longer execute juveniles. In a 1988 case, Thomas v. Oklahoma, the United States Supreme Court determined that national standards of decency did not permit the execution of any offender under the age of 16 (USSC 1988). Behind this “decency” is the belief that children are not fully responsible for their acts.

Development is an ongoing process without clear cut-offs. Not surprisingly, until 2005 there had been controversy regarding older adolescents and the death penalty. In the 2005 Roper v. Simmons case, Simmons planned and committed a capital murder at the age of 17. After he turned 18, he was sentenced to death. A Missouri Supreme court opined that Simmons could not be put to death for a crime committed as a juvenile.

The 8th Amendment addresses cruel and unusual punishment. At the time the constitution was drafted, much of our jurisprudence was based on English Common Law. Children between the ages of 7 and 14 years, if found culpable for their crimes, could be tried as adults and subject to capital punishment; this would not be considered cruel and unusual.

The state’s opinion in the Roper v. Simmons case was fought all the way up to the United States Supreme Court where Justice Kennedy delivered the opinion of the court (USSC 2005). In this 25-page opinion, he cited the Atkins v. Virginia (2002) case, which determined that the 8th Amendment forbids capital punishment of mentally retarded offenders due to diminished capacity. Kennedy stated, “The 8th and 14th Amendments forbid imposition of the death penalty on offenders who were under the age of 18 years when the crimes were committed” (USSC 2002). Justices Stevens and Ginsberg noted that if the meaning of the 8th Amendment had been frozen when it was originally drafted, it would impose no impediment to the execution of 7-year-old children today. The Roper v. Simmons case clearly recognized that juveniles are inherently different from adults, and this recognition was based in large part on our evolving understanding of adolescent brain development and the potential for change and rehabilitation (Leighton de la Vega 2007).

Although the death penalty is no longer permitted for crimes perpetrated by youth, the issue of juvenile life without parole (JLWOP) has remained controversial in the United States. World opinion has come out clearly against JLWOP. The United Nations Convention of the Rights of the Child, ratified by 192 nations, explicitly prohibits the imposition of life without parole for crimes committed by juveniles. Such sentences (JLWOP) also constitute a

In 42 states and under federal law, children who are too young to legally buy cigarettes are being tried for crimes as adults and, if convicted (of murder), can be sentenced to life without the possibility of parole (Leighton and de la Vega 2007). We live in a country where you cannot rent a car until you are 25 years old, buy an alcoholic beverage until you are 21 years old, or vote until you are 18 years old. Yet, there are currently at least 2,500 youth offenders serving life without parole in United States prisons.

Israel last incarcerated a child without parole in 2004. Tanzania and South Africa have now stated that they will cease this practice and will parole juveniles in all cases. This leaves Somalia as the only other country, apart from the United States, that adheres to the policy of JLWOP. Even Somalia ratified a United Nations Child policy on November 20, 2009, that comes out against this policy of JLWOP. This leaves the United States as the only country in the world that continues with JLWOP. The United States still has not signed the United Nations Convention on the Rights of the Child. In March 2009, the AACAP Assembly of Regional Organizations passed a draft policy statement on JLWOP. By June this policy was approved by the AACAP Council and it is now the policy of the AACAP to oppose JLWOP, consistent with the United Nations Convention of the Rights of the Child. As a nation, we must sign onto the United Nations Convention and not be the only country that continues to incarcerate juveniles for life without parole.

The AACAP and the American Medical Association jointly filed a Friend of the Court Brief – an amicus brief – asking the Supreme Court to consider the scientific research showing that adolescents in general are not capable of the same rational behavior and decision-making as adults, especially in acute situations. On May 17, 2010, in a 6-3 decision, the Supreme Court ruled in Graham v. Florida that “it is unconstitutional to sentence a juvenile offender to life in prison without parole when the crime does not involve murder.” At least 129 juveniles sentenced to life without parole will be entitled to resentencing. However, there are still 2,500 people imprisoned as juveniles without the possibility of parole.

The reality is that many juveniles face atrocities when incarcerated. Those juveniles that are incarcerated for life without parole develop a very different view of life. Their ability for free thought and their hope for the future progressively diminishes. We, as child and adolescent psychiatrists, must stand up for the rights of children and for others who do not have a voice. We can do so by supporting the United States signing onto the United Nations Convention of the Rights of the Child. It opposes juvenile life without parole regardless of the crime! ■

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During the weeks following the January 2010 earthquake, the Haitian-American Psychiatric Association (HAPA) consulted with New York University (NYU) School of Medicine to provide disaster mental health training for Haitian-born psychiatrists in the United States. Frantz N. Moise, M.D. – a Haitian child and adolescent psychiatrist practicing in Huntington, New York – participated in disaster mental health training through New York University and returned to his country to assist with relief efforts. He kindly provided the following reflections describing the return to his home country in February 2010.

Frantz N. Moise, M.D.

I traveled with a team of psychiatrists to Haiti on February 9, 2010, by invitation from Partners in Health to perform a mental health needs assessment. We stayed in the Plateau Region which had been minimally disrupted by the earthquake. Nevertheless, the health care system in the Plateau Region was just as overwhelmed as services at the epicenter. Our team visited several localities, conducting memorial services to provide emotional support to grieving families.

The earthquake affected millions of children who – as I prepare this manuscript – are homeless and orphaned in a country where governmental social support for infants and children was already minimal to nonexistent. I believe that all children in Haiti will be affected by the disaster – not only because of the magnitude of the disaster – but also because the child welfare systems of industrialized countries are nonexistent in Haiti, rendering the country unavailable to protect the safety and welfare of children.

During a meeting of the Haitian American Psychiatric Association in New York prior to my return to Haiti, one member indicated that there were more psychiatrists in the meeting room than there are in the entire country of Haiti. He proceeded to share that there are more psychiatrists on staff in the American hospital in which he works than there are in all of Port-au-Prince. These observations reflect the painful reality of the state of Haitian mental health services. I would also point out that these statements referenced only the number adult psychiatrists – without mention of child and adolescent psychiatrists and clinicians from other disciplines such as social work and psychology.

Haiti does not have the luxury of trained child and adolescent psychiatrists to meet the needs of the country’s youth. Most of the services and interventions that the children require following the earthquake are provided by Non-Governmental Organizations (NGOs) that have flocked into the country since January 12, 2010. These NGOs are not able to adhere to any methodology of government protocols in their provision of services because the country does not have a published mental health policy. Treatment protocols and assessment tools to help identify those in need of intervention are nonexistent.

In earthquake-affected regions outside of Port-au-Prince, orphanages have sprung up to meet basic needs of orphans, as well as children whose parents are unable to provide for them. In Jacmel, an orphanage worker called on the Diaspora to bring support to some of the early emotionally affected children at the first month anniversary of the earthquake. Although they have altruistic intentions, these organizations need to confront some of the cultural and linguistic issues or barriers that the mental health field has confronted in other countries.

Regrettably, I do not feel that my return to Haiti brought comfort to others or facilitated change within an effectively non-existent mental health system.
Unfortunately, Haitian children plagued with symptoms of anxiety and depression in the aftermath of earthquake will go unnoticed until we are able to teach the school system to adequately screen, identify, and recommend interventions to alleviate suffering among Haitian youth.

AACAP Members Dina Frid, M.D., and Suzan Song, M.D., M.P.H., reflect on the time that they spent in Haiti assisting with humanitarian parole evaluations. Dr. Song recently completed her child and adolescent psychiatry residency at Stanford University School of Medicine. Dr. Song has been involved in global mental health initiatives in South Africa, Ethiopia, Sierra Leone, Liberia and now Haiti. Dr. Frid pursued training in child and adolescent psychiatry through the San Mateo-Stanford Community Track Fellowship. Having conducted mental health field work in the Dominican Republic and Haiti, Dr. Frid hopes to devote her career to working with underprivileged children in the United States and abroad.

Dina Frid, M.D., and Suzan Song, M.D., M.P.H.

When the earthquake shook Haiti on January 12, 2010, many of us wanted to help the innocent Haitian civilians covered in white ash, with terror and fear in their eyes. As clinicians, our hearts ached as we imagined the aftermath of massive personal, tragic losses.

But as child and adolescent psychiatry fellows, we wondered what our role would be, and how we could become involved in a meaningful way. Our attending at Stanford University, Victor Carrion, M.D., invited us to join a team of human rights lawyers, attending psychiatrists, a medical student, interpreters, and a multi-media artist, to assist in seeking out some of the most severely medically and psychiatrically affected people eligible for humanitarian parole.

Humanitarian parole is an immigration status that the Department of Homeland Security can enforce. It allows the most vulnerable to enter the United States for a temporary period of time for an urgent, compelling reason such as life-threatening medical need, or to promote a significant public benefit. We have used it in the past for Hungarians escaping communism, Cubans fleeing their country, Indochinese migrants who fled at the end of the Vietnam War, and others from China, Iraq, El Salvador, India, Iran, and Lebanon to name a few.

Haiti, despite the devastation and rubble, is a country of vibrant colors. The artwork is lively, and an accurate reflection of the people and their spirit. To see children smiling, glowing with an inner energy and strength, as they spoke about their families dying, tugged at our hearts. We were touched by the optimism of their smiles and concerned that the social support they need for resiliency may not be available.

A five-year-old girl was brought by a woman who found her crying next to the rubble where her whole family was killed. This little girl, who lost everyone and needed to be carried because of a broken femur, emitted a precious flame and melted our hearts with her remarkable smile and laugh. It was immediately clear that this stranger who was caring for her had formed a strong attachment, and watching them interact, the goodness of fit was obvious. The little girl drew pictures and played peek-a-boo and clapping games, her liveliness transcending all language barriers.

We faced personal and professional challenges: that of boundaries – wanting to house, feed, and cry with each individual we spoke with; of ethical struggles – the wish to stay longer and provide therapy to those obviously suffering; and of our own self-care – as our anger grew, after hearing story after story of women and girls being raped in their tent communities, without protection, let alone food, water, or shelter.

These experiences helped us become better clinicians. Stepping outside of our daily practices and having our lives touched by people who have been innocently violated brought us closer to our clients at home. Those granted parole are allowed temporary legal status, opportunities for employment, and Medicare services for the duration of the emergency. Hopefully, we will have the opportunity to work with Haitians here, providing longer-term clinical care.

When we think about the brilliant colors that show the vivacious spirit of the Haitian community, we think of their strength, sense of community, pride, and dignity. The gift of unforgettable moments of deep emotional connections will forever live in our hearts. Rebuilding in Haiti will require an international effort and we look forward in our role as child and adolescent psychiatrists to have an impact on a mental health system that can help foster resilience and address those most vulnerable.

Dr. Davis graduated from the child and adolescent psychiatry residency at the New York University School of Medicine in June 2010. He serves as the John E. Schowalter, M.D., Resident Member to Council. He can be contacted by e-mail at Glen.Davis@nyumc.org.
The American Academy of Child and Adolescent Psychiatry’s (AACAP) Congressional Fellowship Program provides child and adolescent psychiatrists with an invaluable introduction to the workings of a congressional office or committee. The program is designed to educate policy makers and Congressional staff about child and adolescent psychiatry and to foster awareness of children’s mental health issues within the policy arena. This experience will allow the Fellow to have a keen understanding of how laws affect patient care, research, medical education, and healthcare issues by learning the political process from the inside.

Awardee will receive:

★ $85,000 honorarium
★ Up to $3,000 in relocation or moving expenses

The application deadline is December 1, 2010. Notification of the award will be given in early Spring 2011.

Please send completed applications to:
Department of Government Affairs
Congressional Fellowship Program
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
**Psychiatric Practice**

**Presidential Initiative Supports Psychotherapy Research**

_CAPP is not a treatment developed in a laboratory and then promoted to practitioners for acceptance. Rather it is a systematization of treatment that clinicians have developed over decades of work with patients._

Rachel Ritvo, M.D.

AACAP President, Laurence L. Greenhill, M.D., has committed $20,000 from his presidential initiative to pilot funding to develop a testable form of psychodynamic treatment for anxious children and adolescents: Child Anxiety Psychodynamic Psychotherapy (CAPP). Many AACAP members fear that the empirical research needed to anchor psychodynamic work with children in the “evidence-based” practice of today will simply never get off the ground. As Andrew Gerber, M.D., pointed out in his presentation at the AACAP 2009 Research Day in Honolulu, Hawaii, the quantity and quality of randomized control trials (RCT) for adult psychodynamic psychotherapy, gauged by a 25-item quality measure developed by the American Psychiatric Association’s Workgroup on Research, has been steadily rising. There are very few credible outcome studies of any form of psychodynamic psychotherapy for children and adolescents.

Dr. Greenhill began his efforts to promote the development of sound empirical research in child and adolescent psychodynamic psychotherapy while he was chair of the AACAP Research Work Group and before he won election to the AACAP presidency. In 2006-2007, Dr. Greenhill approached Tim Dugan, M.D., and Efrain Bleiberg, M.D., co-chairs of the AACAP Psychotherapy Committee, with a request that the Committee develop a proposal for the Work Group on Research for an AACAP initiative focused on psychotherapy. Dr. Greenhill asked Research Work Group member Barbara Milrod, M.D., winner of the 2004 AACAP-Rieger Psychodynamic Psychotherapy Paper Award, to be the liaison from the Work Group on Research to the Psychotherapy Committee. Dr. Milrod’s work developing the manual for Panic Focused Psychodynamic Psychotherapy (PFPP), and taking PFPP through successful clinical trials in adults, made her uniquely qualified among AACAP members to help Dr. Greenhill and the Psychotherapy Committee develop a plan.

Drs. Dugan and Bleiberg responded in September, 2007:

“At this point in time it appears that nearly all institutional support for child and adolescent psychotherapy research is going into cognitive behavioral treatments. Although the Psychotherapy Committee wishes there were more support for research across the board, the Committee feels that the need to bring psychodynamic psychotherapy research up to par with cognitive behavioral research is sufficient to recommend that this initiative from the Work Group on Research be focused on psychodynamic psychotherapy. AACAP is uniquely positioned to advocate for the resources needed to bring psychodynamic psychotherapy with children and adolescents to an EBT [evidence-based treatment] standard. AACAP members are traditionally invested in psychodynamic psychotherapy.

An interdisciplinary panel of renowned psychotherapy researchers was convened and met through a series of conference calls. AACAP members on the panel (Judith Cohen, M.D., John March, M.D., Linda Mayes, M.D., Barbara Milrod, M.D., Ted Shapiro, M.D., and Hans Steiner, M.D.) were joined by Jacques Barber, Ph.D., and Kenneth Levy, Ph.D., of the University of Pennsylvania and Peter Fonagy, Ph.D., of the Anna Freud Centre, London, England. The talents and experience of this assemblage were reflected in the recommendations they produced.

Children with anxiety disorders, a cohort for which psychotherapeutic interventions tend to show good responses when evaluated clinically and retrospectively, were recommended as a target of study. Dr. March’s familiarity with the NIMH supported Child Anxiety Multimodal Treatment Study (CAMS), then in progress and for which he served as a principal investigator, facilitated consideration of a study design that would parallel the intake and outcome measures of the CAMS. Child psychodynamic research has been hindered by a dearth of manualized protocols for administering this treatment. Drs. Milrod and Shapiro brought to the panel their successful experience developing the PFPP manual for the treatment of adults.

Dr. Fonagy also had experience developing manuals in the United Kingdom. These three volunteered to develop a manual with the hopeful expectation that AACAP could support, through funds and advocacy, the initial testing of the manual in a clinical population of 8 to 16 year olds.

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Drs. Greenhill, Dugan, and Bleiberg encouraged the manual development team to proceed. The manual was drawn up based on state of the art psychodynamic understanding of the problems of anxiety in children and treatment approaches that are consistent with the approaches currently in use by psychodynamic practitioners. CAPP is not a treatment developed in a laboratory and then promoted to practitioners for acceptance. Rather it is a systematization of treatment that clinicians have developed over decades of work with patients. A 24-session, twice-weekly intervention, CAPP aims at helping 8 to 16 year olds who meet DSM-IV criteria for primary general anxiety disorder (GAD), social anxiety disorder (SAD), or social phobia to alleviate anxiety symptoms via enhanced self-understanding of emotional responses in the context of their fantasies, wishes, beliefs, and desires in relation to important figures in their lives. The intervention is based on the understanding that anxiety arises out of the inability to think about the relationship between anxiety and these issues. It is expected that the therapy will improve their Reflective Function as well as improve their impairment ratings on the Anxiety Disorders Interview Schedule for DSM-IV, Parent and Child Versions, the Clinician Severity Rating, and other rating scales used in CAMS.

The resultant “Pilot Funding Proposal for Manualized Time Limited Psycho-dynamic Psychotherapy for Anxious Children and Adolescents” arrived at AACAP in the fall of 2008. The proposal was for an open clinical trial of CAPP in 15 children and adolescents, aged 8 to 16 years old. The specific aims were to complete development and validation of an adherence measure, to establish a training protocol to enable psychodynamic therapists to train to adherence in CAPP, and to establish that those trained to adherence achieve significant improvements in a group of children with a diagnosis of any of the three primary anxiety disorders. Dr. Greenhill had by this date been installed as president-elect. The new chair of the Work Group on Research, David Shaffer, M.D., did not have a plan for continuing the project. Fortunately, as things were being sorted out at AACAP, Dr. Shapiro applied for, and was awarded, a grant from the research fund of the American Psychoanalytic Association, and Dr. Milrod was able to gain some funding from the International Psychoanalytic Association. This was sufficient to keep the project moving. Dr. Greenhill moved forward with his presidential initiative, making the CAPP Pilot Funding Proposal eligible for AACAP support.

For the many AACAP members who have wondered how child and adolescent psychiatrists will ever get psychodynamic psychotherapy research for children and adolescents underway, Dr. Greenhill’s presidential initiative comes as a welcome lift and a reminder that we can accomplish more through our participation in AACAP than any one of us can accomplish alone.

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Cartoon by Stuart Copans, M.D.
Mentorship Matters: The Klingenstein Third Generation Foundation Sponsors Programs that Foster Interest in Child and Adolescent Psychiatry

During the course of my involvement with the KMSP, I have harnessed a tremendous respect for my buddy’s ability to adapt and maintain a hopeful and caring attitude while enduring significant stressors. — Kathy Lee, KMSP Fellow

Every day between packing my bag and entering the lecture hall of the medical education building, I pass churches, stores, schools, restaurants, and countless homes. These daily commutes comprise only a small proportion of my day, but often offer a much-needed escape from lists, mnemonics, and flashcards, and a return to reality. As refreshing as they are, these moments only transiently and superficially satisfy the urge that I believe most medical students have to interact with and understand the communities that surround us.

For the past year and a half, I participated in one of several programs that connect medical students with the Baltimore community while supplementing our medical school education. The Buddy Program was new when I joined during my first year at Johns Hopkins School of Medicine. Part of the Child and Adolescent Psychiatry Interest Group, the program pairs each participating medical student with a local elementary school student who has been diagnosed with a psychiatric illness.

The Buddy Program pairs each participating medical student with a local elementary school student who has been diagnosed with a psychiatric illness. The younger buddies attend an urban Baltimore public school near the medical school campus. Once a week, the buddies meet after school to participate in a variety of activities, from playing games to making art to walking in a nearby park.

The dynamics between pairs of buddies varies widely. One medical student often acts as an advocate for her buddy, who faces language and cultural challenges at school because her family recently immigrated to the United States. Another medical student faced the challenge of

The Klingenstein Third Generation Foundation was established in 1993 through a capital grant from the Esther A. and Joseph Klingenstein Fund. The Foundation seeks to:

- Encourage a meaningful, long-term contribution to the field of child and adolescent ADHD and depression by supporting relevant, cutting-edge scientific research;
- Enlarge the academic and research pool by nurturing the talents of high-quality medical students and graduates from medical schools and graduate programs; and
- Encourage major medical institutions to support young investigators in the critical early stages of their careers.

Based on the Foundation’s concern there are too few child and adolescent psychiatrists to serve the needs of children in the United States, the Klingenstein Medical Student Program (KMSP) is integral to the mission of the Foundation.

The Foundation funds ten medical schools across the country to develop and implement programs to effectively recruit medical students into pediatric psychiatry. Inspired by the late Donald J. Cohen, M.D., the first KMSP was established at the Yale Child Study Center in 2002. The program met with such success that the Foundation expanded its funding to ten medical schools. Each school has created a unique program to reach the Foundation’s goal while sharing two common components: The programs offer mentorship and clinical experiences to interested students; and the programs facilitate discussion groups, exposure to research, networking opportunities, and visits to professional conferences.

Below, a group of medical students highlight unique aspects of two of the KMSPs.

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an extremely anxious buddy exhibiting a pattern of inconsistent attachment, sometimes reaching out to the medical student, but often withdrawing from their relationship. A third medical student works with a buddy whose severe behavioral problems and intermittent psychiatric hospitalizations interrupt their weekly sessions of basketball and homework tutoring. The nature of the relationships between buddies is diverse, but each medical student offers a stable weekly presence that I believe makes a difference in the lives of troubled youth.

Outside of the Buddy Program, medical students benefit in other ways from the KMSP. The program provides medical students with an opportunity to connect with the Baltimore community. The program encourages students to take a break from the rigor of basic science lectures and clinical rotations to spend time with underprivileged children and families. The KMSP encourages medical students to develop long-term relationships with their buddies. For students who are interested in psychiatry, the opportunity to get to know individuals in the community over an extended period of time is an attractive aspect of the program that is unparalleled in the formal medical school curriculum. I have seen my buddy navigate difficult social situations at school, move apartments, grieve over the death of a family member, and successfully cope with other major life transitions.

During the course of my involvement with the KMSP, I have harnessed a tremendous respect for my buddy’s ability to adapt and maintain a hopeful and caring attitude while enduring significant stressors. The complexity of my buddy’s emotional and behavioral response to the events in her life often fascinates me. My evolving relationship with my buddy has strongly reinforced my interest in child and adolescent psychiatry.

Relationships between mentoring medical students and community youth in the Buddy Program can be quite intense. Therefore, the success of the Buddy Program has been due largely to the resources that the KMSP provides to participating medical students, who vary widely with regard to their previous experiences with children. I had never worked with children when I joined the KMSP, and I have tremendously benefitted from learning how to connect with children and reacquaint myself with common childhood behaviors.

Justine J. Larson, M.D., M.P.H., Assistant Professor of Child and Adolescent Psychiatry at Johns Hopkins, founded the Buddy Program which was initially funded through a teaching grant from the American Psychiatric Association. Dr. Larson is heavily invested in pairing students with buddies, fostering a positive dynamics between them, offering advice about how to approach challenging situations in the student-buddy relationship while strengthening the mentorship between medical students and their buddies.

Medical students also benefit from interacting with the elementary school guidance counselor in the community, who offers valuable insight into their buddies’ academic and social life in school while also educating the medical students about the public school system. Each medical student is also paired with a faculty mentor in the Division of Child and Adolescent Psychiatry at Johns Hopkins. Mentors provide buddy’s advice as well as general career and life guidance. Finally, the Child and Adolescent Psychiatry Interest Group hosts monthly seminars, inviting first and second year medical students to learn about a topic in the profession. Many of the subjects are chosen based on the issues that arise in the Buddy Program, providing a clinical and research context for the daily challenges that the younger buddies frequently face.

The Buddy Program has grown significantly since its inception, and it continues to evolve. Ongoing issues include how to expand the program while maintaining a group of medical students who maintain a commitment to their participation. KMSP participants also struggle with how to say goodbye to the children when it is time to end the relationship. There are also perennial logistical issues related to the facilitation of the Buddy Program, such as ensuring that younger buddies return home safely after meeting with their student mentors. Though a work in progress, the Buddy Program is a catalyst for meaningful relationships and learning opportunities. Witnessing the development of the Buddy Program of the Johns Hopkins KMSP has undoubtedly been an enriching component of my medical school education.

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Program II: Mayo Medical School Child and Adolescent Psychiatry Mentorship Program

Chad Kritzberger, Caitlin Loprinzi, and Beth Angstman

The Mayo Medical School Child and Adolescent Psychiatry Mentorship Program, an initiative facilitated by medical students at Mayo Clinic under the guidance of Lloyd Wells, M.D., Director of the Mayo Klingenstein Program, plays a unique role in teaching patient-centered care. The program, which pairs medical students with children and adolescents on the inpatient psychiatry service, was inspired by a publication in the AACAP News: “The Story Time Project.” The Story Time Project was started by then medical students Dana Kaplan, M.D., and Marieccl Pilapil, M.D., at the Mount Sinai School of Medicine as a means for medical students to volunteer on the pediatric inpatient psychiatry service. Medical student and resident participants in the Story Time Project would visit the inpatient unit once a week to
read and discuss age-appropriate stories with children and adolescents who did not have family or friends to visit them during guest hours. The Story Time provided medical students with an opportunity to enrich therapeutic activities on the inpatient child and adolescent psychiatry services while exploring the profession of pediatrics and psychiatry. Drs. Kaplan and Pilapil wrote that they hoped their program would “create a tiny sense of consistency and nurturance that will be paired with fond memories of reading” (AACAP News, July/August 2008). At Mayo Medical School, we hope that the Child and Adolescent Psychiatry Mentorship Program creates a similar sense of consistency and nurturance, as well as fun-filled experiences by providing young patients with a friend and mentor during their inpatient stay.

The mentorship experience begins when Dr. Wells identifies a child who would benefit from a mentor. The mentor request is sent to interested medical students through an e-mail list. Once a medical student demonstrates an interest in mentoring the child, the match is made, and the student contacts the child’s nurse to schedule an appropriate visitation time. Students typically visit one to three times per week during the course of the child’s hospitalization.

Though the program started less than one year ago, meaningful mentorship experiences have already taken place. Emily, a smart, athletic, driven, and personable eighth grade girl was mentored for many weeks while recovering from anorexia. The patient and her mentor both loved sports and had similar academic goals, which helped them to develop a strong therapeutic relationship. Over the weeks, there was a transformation in Emily. Her mentor counseled her about positive outlets for her perfectionism, such as working toward achieving the goal of a college athletic scholarship. While Emily found a friend and source of support through the experience, her mentor had a privileged opportunity to learn about mental illness and observe the process of recovery.

In another instance, a 10-year-old boy with depression, stemming in part from the sudden loss of his father, was found to be lacking positive attention from other males. One of our male medical students provided this attention by doing math trivia with him and looking through the boy’s favorite magazines together. In turn, the patient began to feel more accepted by others on the service, and the mentor gradually observed a remarkable transformation in the patient from severely depressed to happy and outgoing.

The success of the mentorship program is exemplified in a mentoring friendship between an Arabic speaking second year medical student and a thirteen-year-old girl from an Arab country who could not speak English. For over a month, the student and patient spent time talking and playing games two to three times a week. By the end of the patient’s hospitalization, the mentor had become a trusted friend. The girl was enthusiastic about having a person in the hospital who understood her culture and language. Dr. Wells noted, “The patient shared far more with her mentor than she did with the staff or interpreters, and this was often extremely helpful to us.” An additional benefit of this mentorship experience was the insight and translation of cultural norms that the mentor could convey to the patient’s physician. Certain markers of maturity that are used for American adolescents incorrectly led the health care team to conclude that she had delayed emotional maturity. The presence of the medical student corrected this conclusion, providing the mental health team with information to optimize the patient’s care.

The mentoring experiences described above have provided the program leaders with antidotes about its effectiveness. An Internal Review Board approved research study is underway to evaluate the success of the program in improving the quality of the patient’s treatment during hospitalization. Preliminary data indicates that patients are grateful for the mentorship program, and we hope to continue that trend in the future.

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Caitlin Loprinzi is currently a third year medical student at Mayo Medical School. She obtained a B.S. in Biology from Iowa State University in 2008.
An 11-year-old youth is placed in a group home with a history of perinatal drug exposure, and a history of physical abuse, neglect, and various other adverse life circumstances. He has a history of severe problems, including ADHD symptoms, and aggressive and self-endangering behaviors culminating in several placement changes. He is prescribed clonidine, quetiapine, and divalproex sodium with very limited appreciable, beneficial effect in attenuating his behavioral/emotional symptoms.

The above vignette is common in the child welfare system. As child and adolescent psychiatrists, most of us have encountered numerous clinical situations of complex psychopathology and management predicaments.

The term ‘overuse’ in reference to psychotropic medication implies excessive prescribing, either through multiple different medications and/or high dosages of medications. Such overuse may be identified in clinical practice or through review of medical databases (Crismon and Argo 2009) (Steele and Buchi 2008) (Zito et al. 2008). In May 2008, the House Ways and Means Subcommittee on Income Security and Family Support held a hearing focusing on previous reports of potential overuse of psychotropic medications among foster children (dosReis et al. 2001). This article considers the possible mitigating factors and presents principles of remediation that could facilitate appropriate use of psychotropic medication treatments of children and youth in the welfare systems.

Possible aggravating factors:

Assessment Issues: A practical issue is the time constraint that may limit obtaining and integrating assessment information. Unlike usual child and adolescent psychiatry evaluations where the child is accompanied by at least one parent, there may not be a primary informant who is chronologically familiar with the child to provide information. Records of child welfare departments are often extensive and it can be a daunting and time-consuming task to review the records to elicit relevant assessment information.

Diagnostic issues: Detailed information may be fragmented and/or absent during assessment which increases the potential for incorrect diagnoses and inaccurate formulations. This can lead to misguided treatment planning.

Complexities of psychopathology: Children in the child welfare systems are more likely to have a history of perinatal adversities (e.g., exposure to illicit substances, inadequate perinatal care, maternal stress, etc.) These children may also have a higher propensity for various other adverse life experiences in addition to abuse or neglect illustrating the adage – when it rains, it pours. The multifaceted nature of presenting problems offers an array of target symptoms to address which may potentially warrant multiple DSM Axis I diagnoses and simultaneous treatment with different classes of psychotropic medications. Developmental insensitivity of trauma-specific diagnoses has added to the complexity of accurate diagnosis.

Excessive reliance on medications to attenuate symptoms: As physicians, because of the nature of training with emphasis on biological causes of problems, the prescriber may be more readily inclined to target symptoms with pharmaceuticals (Hojman 2010). Another factor could be a sense of urgency or ‘pressure’ to attenuate symptoms which are jeopardizing placement stability.

Non-medication treatment modalities: The focus of therapeutic interventions could be misdirected due to inadequate assessment and misidentification of target issues in therapy. Environmental factors like interpersonal issues with caregivers or peers in group homes or foster family members could be perpetuating factors that may warrant other management interventions. Inadequate training, experience, and/or supervision of clinicians providing non-medication therapeutic modalities can also be a factor.

Principles of remediation:

Establishing standards of evaluation: Obtaining information from multiple sources is essential. Use of a structured assessment format and/or assessment tools (e.g., Achenbach Child Behavior

Training of child and adolescent psychiatry residents, as well as general psychiatry and pediatric residents, should focus on the awareness of this conundrum.
Checlist; UCLA PTSD Reaction Index; Trauma Symptom Checklist for Children) can facilitate adequacy of evaluation.

Follow up information: During follow up visits, besides the target symptom and medication monitoring protocols, other parameters should be reviewed. These should include reassessment of stressors, reviewing current functioning, ascertaining perpetuating factors, and efficacies of non-medication treatment modalities. It is also important to ascertain absence of maltreatment.

Training: Training of child and adolescent psychiatry residents, as well as general psychiatry and pediatric residents, should focus on the awareness of this conundrum. Child and adolescent psychiatry residency training should entail learning leadership skills to orchestrate multidisciplinary teams, as well as familiarity with available resources in the community for these children. Child and adolescent psychiatrists are the optimal provider of medication support services for these children due to their specialized training. However, the workforce shortage of child and adolescent psychiatrists needs to be addressed.

Use of evidence-based therapeutic approaches: There is a growing body of evidence-based medication as well as non–medication therapeutic approaches. Non-medication evidence-based treatments like cognitive behavioral therapy (CBT) and interpersonal psychotherapy for depression; and trauma focused cognitive behavioral therapy (TF-CBT), child-parent psychotherapy and Cognitive Behavioral Interventions for Trauma in Schools for traumatized children can be extremely effective in mitigating distressing symptoms and may have potential of decreasing or terminating the need for medication treatments.

Monitoring: Dependency Courts should have a system of approving psychotropic medication prescribing based on liaison with child and adolescent psychiatrist(s) to review and ascertain appropriateness of prescribed medication regimens.

Economic considerations: The issue of overuse of medications cannot be adequately contemplated without fiscal considerations: We have to put our money where our mouth is. The Medicaid reimbursement rates are typically very modest and consequently results in significant constraints on the time allocated for evaluation, as well as review and follow up of the children. Ironically, certain medications that are often prescribed for these children (e.g., the second generation antipsychotics) tend to be very expensive for the Medicaid system and potentially excessive use may offset the money ‘saved’ from lower reimbursement rates.

Technology: In the near future, electronic records will likely become the norm across the United States. It is very conceivable to have a ‘master record’ of assessment/reassessments and treatments in a chronological format that will mitigate the fragmentation of information that we currently experience. This, hopefully, will result in improved quality of care of children who often have frequent changes in their service providers.

Peer review: An organized system of peer review of medication treatment regimens in complex cases would be helpful. If a non-child and adolescent psychiatrist is providing medication support services, consultations/teleconferencing with child and adolescent psychiatrists could be helpful.

In summary, although it is possible to “justify” relatively more children in the welfare system receiving psychotropic medications based on the higher prevalence of mental disorders than in the general population (dosReis et al. 2001), our efforts should be to ensure that these children receive the highest possible quality of comprehensive mental health services.

References

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The Keys to Opening a Private Practice
Part 1: The Business Aspects

Opening a private practice takes careful planning to ensure that the process goes smoothly. This first of two articles focuses on the business aspects of opening a practice, while the second article will focus on the “nitty-gritty” details of the process. This assumes you are starting a full-time practice from scratch, rather than joining an existing practice or subletting a furnished office.

Setting up your practice means you are opening a business in which you will be providing psychiatric services. It helps to think like a business person. Where are my services needed? Who are my potential “customers”? Who is able to afford my services? Who are my potential referral sources? The answers to these and related questions should help you decide where to set up practice. The further one locates a private practice from an academic training program, the greater the need for services. However, that does not always translate into referrals if much of the population cannot afford private services or does not value professional care. Areas with higher incomes, higher educational levels, and new population growth are likely spots to locate a new practice. Avoid opening an office just because it is convenient to where you live, if it doesn’t meet these other criteria. Moving to a different community with a need for child and adolescent psychiatrists in private practice may be the best way to ensure you will be in immediate demand.

It is helpful to do a “market analysis” of the community you are considering. This is different than looking at the demographic characteristics just mentioned. Talk to other child and adolescent psychiatrists, other mental health professionals in private practice, pediatricians, and possibly even a banker or two (to see about the availability of loans). This information will give you a reasonably accurate measure of how much a new child and adolescent psychiatrist would be welcomed in the community.

Carefully look at what you want to accomplish in setting up your practice. How does operating a practice mesh with your personal life and your professional goals? Financial success is not the only measure of success. For example, you may be willing to limit your income from your practice to have more time with your family or to have more flexibility to pursue other professional goals. The demands of a busy full-time practice make it easy to lose sight of these other parts of life if you do not plan for them.

Once you have selected a community, look for a location that will be conducive to a new practice. Since access is important, consider sites near major intersections or public transportation and with available parking to make it easier for prospective patients. Next consider what kind of office situation will work best for you. Joining an existing group greatly simplifies the set-up process but may limit your income and scheduling flexibility. Co-tenancy is another option that allows some of the collegiality of a group practice without the restraints, but also without the supports. Avoid joining a group just because they want you. This may be their opportunity to give the unsuspecting newcomer their clientele with low-paying insurance. Be sure to vet any professionals with whom you are considering associating.

If you find yourself in the situation of needing to rent new office space, you will need to start that process about six months prior to opening your practice. This is especially important if you want to be in a good position to negotiate lease terms with the new landlord. If you get too committed to a certain office or are rushed for time, your negotiating power diminishes. Using a commercial realtor is helpful in this process.

Unless you are renting an office previously set up for a mental health practice, there are a number of important tenant improvements that you will need, especially soundproofing in the walls, ceilings, doors, and window junctures. These are sometimes expensive improvements and the cost will be added into the lease. Another alternative to be considered would be a home office which would involve renovating a house or apartment with appropriate zoning to enable you to practice with the requisite patient privacy. A home office allows you to take tax deductions related to the portion of the space used for your office and has other advantages.

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Jack C. Westman, M.D.

I was delighted to be invited to reflect on my career in child and adolescent psychiatry, actually in family psychiatry. I have enjoyed my work so much that it would be easy for me to write about all of the good things I have seen happen. As has been the case with most of us, working with young people has kept me young at least at heart! We certainly can be pleased with the progress our field has made over the years. The Academy (AACAP) has become a potent clinical, academic, and scientific force.

However, rather than recounting my perceptions of our progress as a professional field, I feel an obligation to our young people and their families to “tell it like it is.” This perspective may be useful to younger colleagues who have not lived through the Great Depression, World War II, the Korean War, the Cold War, the Vietnam War, and the Gulf War.

There was a time when all of the schools in our country, urban and rural, functioned well. Discipline problems were chewing gum in class, getting out of line, tardiness, and an occasional fist fight that was a cause celebre for days thereafter.

Now classroom control is a major issue in most of our schools, and one-third of our young people are not doing well. At least 11 million have been damaged by abuse and/or neglect; 13 million live in poverty; 20 percent have been identified as having some sort of mental disorder; and 145,000 are born annually to school age mothers.

My concern about the deterioration of the lives of young people in the United States began to influence my professional life in 1970 when the last of a series of very productive White House Conferences on Children and Youth (the first was in 1909) suggested that our nation was failing its children. That conclusion was affirmed in 1991 by the National Commission on Children.

My concern reflects my approach to the practice of medicine. In addition to the usual desire to help people, curiosity about what makes people tick led me into psychiatry. I always have wondered, and continue to do so, why people do things that appear to be self-defeating. This led me into child and adolescent psychiatry where I could literally go from “neurons to neighborhoods” and even beyond to the society in which we live.

Our first child and adolescent psychiatrists were grounded in the anatomy and physiology of the brain because of the obvious influence of “brain injury” and “minimal brain dysfunction” in early life. We were the first physicians to use psychoactive agents effectively and the first to establish Community Mental Health Centers in the form of Child Guidance Clinics.

Looking back, I am impressed by what we accomplished through the Child Advocacy Service at the University of Wisconsin, which was established in 1980. The Service formed interdisciplinary teams around each troubled family. Similar teams now are working throughout the nation in the form of Wrap-around or Coordinated Services Teams.

When I retired in 1997, Bob Sundby, an appellate court judge, and I formed Wisconsin Cares, Inc., a volunteer lobbying organization for children and families composed of colleagues from a variety of disciplines who were retiring at that time as well. This organization has had some influence in the political system and is a source of satisfaction to its members.

My own writings have been devoted to relating our insights as child and adolescent psychiatrists to education, human services, law, public health, and public policy. I observed that “kids having kids” is the most preventable source of our social problems, especially crime and welfare dependency. This led to my most recent book in 2009, Breaking the Adolescent Parent Cycle: Valuing Fatherhood and Motherhood.

In the 1970s, it dawned on me and Chester Pierce that prejudice based on age, ageism, could apply to the young as well as the elderly. Since then, awareness of the existence of juvenile ageism has helped me understand why children can be oppressed, tortured, damaged by drugs, and murdered under the less graphic and compelling label: child abuse and neglect. It has helped me understand why public rhetoric about our devotion to children is not matched by action. It has helped me
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and disadvantages requiring consideration.

At this point in the process, you will probably be eager to set up your office and to buy furniture, office equipment, and all the other things your office will need. All this takes money, although sometimes you can start out simply and relatively inexpensively and upgrade as your income improves. If you do require a line of credit from a bank, you will need a business plan.

The business plan consists of a statement about you (or your group), the services you plan to provide, your market analysis of the need for your services, how you plan to market your services, one-year and five-year plans, a capital expense budget (the cost of all the stuff you plan to buy to set up your office), an operating budget (estimated income and expenses month-by-month) for the first year of operation, and the amount you already have to invest in this venture. This actually takes a fair amount of footwork plus some educated guesses to come up with numbers. Do not worry about being too accurate, especially with the estimates of income. The important thing is to show your lender that you have tried to think this through. The lender may even have some useful suggestions for revising your business plan. The bottom line is the amount of money you will need not only to buy all that office furniture and equipment, but also to help sustain you until the incoming cash flow can do that. Often it can take a year or two to establish a steady and acceptable flow of income from a new private practice. Interim options include taking a part-time position, using your savings and having a working spouse. More detailed information about how to prepare a business plan is available on the AACAP Web site in Part II of The Keys to Starting a Private Practice Webinar.

Next, begin marketing your practice. Marketing has a bad rap in professional circles, conjuring up images of glossy ads and used car salesmen. But what good is it to open your practice if no one knows about it? Marketing is just a tool for letting your new community know who you are and what services you offer. There are lots of ways to do this. The best form of marketing is personal. Call pediatricians, psychologists, master’s level therapists, school counselors, and other child and adolescent psychiatrists with very full practices and offer to meet with them. Find out what their needs are and let them know what you can do to help. It is not as scary as you might think. If you did your market research to help you locate a community, you may be talking to the very same people who had encouraged you to come to their community to practice. Certainly it is helpful to offer to give talks to CHADD or the Parent Teacher Student Association, but nothing is as effective as building personal relationships with other professionals in town. Join the regional chapter of AACAP in your new location and other relevant professional organizations. Attend meetings and always bring your business cards with you. Volunteer to be active in your professional organizations so you become known to established leaders in your community.

In the second article on opening a private practice, I will go into detail about other decisions that need to be made and things to be done before you open your office. In the meantime, you may want to look at one of these two books: Entering Private Practice: A Handbook for Psychiatrists, Jeremy Lazarus, Ed., APPI, 2005; or Money and Outpatient Psychiatry: Practice Guidelines from Accounting to Ethics, Cecilia M. Mikalac, M.D., Norton and Co., 2005.

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understand why child and adolescent psychiatrists and pediatricians are at the low end of the medical totem pole.

A current example of our national neglect of young people is that the last of the productive series of White House Conferences on Children and Youth was in 1970, forty years ago. Recently, the White House Conference on Children and Youth in 2010 Act introduced in the 2007-2008 session of Congress was not acted upon. It has been reintroduced as HR 618 & S 938 in the 2009-2010 session.

Looking at ourselves, to the extent that our brand as child and adolescent psychiatrists results in separating the parent-child unit, we contribute to the reductionistic trends of science and our society that obscure the interests of families and our future as a nation.

I hope that our field will continue to work with young people in the context of their families, neighborhoods, and communities. I hope that we will vigorously advocate for strengthening families as the most effective way to ensure that our nation has the social and human capital required for a prosperous future.

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Mind Over Media

“As we become what we behold. We shape our tools and then our tools shape us.”
— Marshall McLuhan, Understanding Media

Jean A. Dunham, M.D.
Resident Editor: Media Page

As a writer, I struggle to find the perfect opening. Something slightly confessional is always good. It confides in the reader, as if letting him in on a little secret. The screen before me tries to help by underlining misspelled words in red and fragment sentences in green. I alter thoughts based on the technology that precedes me. I edit, delete, and process words to dig a path for the message.

All this – movable text, grammar check, even thoughts laid out in horizontal lines to form what we call sentences – are tools we created for self-expression. Long before Freud and Jung captured internal states of mind, artists and poets did so in their chosen medium. The tradition of storytelling kept tribes together, forming communities around the spoken word.

The advent of the printing press changed everything. Reading became central to our habits of mind, so much so that today, the illiterate are at quite a disadvantage. We start introducing ideas early by reading to babies. If you have ever done this, you know that they chew on books much like adults chew on ideas. We enter a text, take in whole arguments, and become fed by words.

Reflecting on my own media diet, I am struck (and a bit horrified) by how much I consume – not only words, but images and sound. I have had to be more selective of what I take in due to technology’s barrage of onrushing stimuli as my evolving media rituals contend with competing forces.

In the mornings, I fantasize waking up and drinking coffee over a real newspaper, but I usually check Twitter instead. NPR accompanies me on my commute to work. If I have a few minutes between patients, I will check e-mail or catch up on a handful of blogs. Music is a necessity and often a regulating part of my diet. At night, I will tuck into a good book. I tweet. I Facebook. And yes, I have even texted my husband who is watching television in the other room.

I wonder how all this media consumption is affecting me. And as a child and adolescent psychiatry resident, I wonder how it is affecting my patients. I speculate that certain faculties are developing, while others are regressing. I know my own reading habits have changed, due in part to the sound bite syndrome plaguing the airwaves. Even the way I use language has changed, as texting abbreviations sneak their way into casual conversation.

Perhaps these new technologies are a bit like learning a language. I am amazed by how quickly children become versed in it. The beholding and the becoming turn literal during critical periods of plasticity. And we grow up shaped by the very tools we create.

The Millennial Generation’s identity is already being shaped as a result of these tools. They are more fluent in new technologies and learn to use them creatively. They are thought to be more peer-oriented by their use of social networking. And they also are more likely to be engaged with politics by “friending” the President online. While I am excited about the possibilities, I also have reservations. For example, the push to multi-task borders absurdity as children text, listen to music, watch TV, and try to do homework all at the same time. Who knows what the impact is, and is there even time to consider it?

The trickle-down effects of mass media catch every facet of our lives and in essence provide a manmade ecosystem. On an international level, the messages sent through sound waves tell us how to perceive other countries. These attitudes permeate the psyche of a nation and can promote a sense of fear or sense of safety. On a cultural level, music can stylize a decade and a single

Helpful Resources:

AACAP Committee on Media
www.aacap.org/cs/root/resources_for_families/kids_and_pop_culture

Center on Media and Child Health
www.ccmch.tv

Media Matters
www.aap.org/advocacy/mediamatters.htm

Kids and the Media
www.apa.org/topics/kids-media/index.aspx

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book, like *Harry Potter* or *Twilight*, can stir the moral imagination among a generation of youth. On an individual level, a photograph can retrieve an isolated memory and a handheld gadget can be a self-object.

As media becomes increasingly multimodal, I wonder how are we developing and what are we becoming? What is in its infancy? What is in its latency? And what is coming into age? And as the millennium opens, how can we as child and adolescent psychiatrists better understand the world of our patients?

*Mind over Media* is my introduction to the Media Page in *AACAP News*. This page will continue to serve as a resource for AACAP members to summarize their recent publications for AACAP members; however, we are also interested in reflective and psychologically minded pieces on any aspect of media today.

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**Did You Know**

New York Yellow Cabs are yellow because John Hertz, the company’s founder, read a study that concluded yellow was the easiest color for the eye to spot.

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**Diane H. Schetky, M.D.**

AACAP Member

*Dr. Schetky has retired from practice. She is the author of* Poems on Loss, Hope and Healing.*

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**Tim Was Here**

It is a near perfect late September day for sitting on the smooth, warm rocks that flank the outer harbor of Rockport. A brazen sugar maple trumpets her colors against the backdrop of Ragged Mountain and a flawless blue sky.

A strong northerly wind helps the Mary Day slip silently through the boats that linger in the harbor. On deck, hands hustle and sails begin to billow. Suddenly, the windjammer soars downwind out into the bay.

This near perfect day is marred only by large black letters on the smooth, warm rocks on which I rest, proclaiming “Tim was here!” and “Tim hates Karen!” Like a dog lifting his leg, he’s left his mark three times.

Nature’s timeless art: boulders sheared by glaciers and smoothed over eons by pounding waves, now seared by Tim’s hatred and his crude claim to fame.

A space sought out by many to sit in peace and quiet contemplation now violated. If only

Tim had come here to cast his anger to the sea and heal his hurt with the lapping of waves and warmth of sun.

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Individuals interested in submitting poetry should e-mail Chuck Joy, M.D., Features Editor at crjoy1@gmail.com.
Vulnerability and Risk
In the last News Updates, I reported on several articles on the complex nature of being “at risk” or vulnerable. This timely topic carries into this News Updates as the complex nature of being at risk or vulnerable continues to be unpacked.

In April’s 2010 Archives of General Psychiatry, Gotlib et al. report on a small study of the “Neural Processing of Rewards and Loss in Girls at Risk for Major Depression.” The study looked at two groups of never disordered 10 to 14-year-old girls. One group was considered at “high risk” because their mothers had suffered from depression, the other group was at “low risk” based upon having no family history. Using functional magnetic resonance imaging (fMRI) they studied the girls’ responses to anticipated gain or loss. They note that deficits in reward processing had been documented before in patients with depressive disorders, but had never been studied prior to the onset of the depressive illness. From a cognitive behavioral standpoint, the functional correlates, under responding to anticipated good and over responding to anticipated bad, also have been well documented. The question as to whether these represent a trait that puts one at risk, or a state that is the product of depression has been unresolved. While the study was small, the authors found clear differences in brain activity, as reflected in each group’s respective fMRI. The authors suggest that long term follow up, to see if these changes predict future depressive episodes is needed.

http://archpsyc.ama-assn.org/cgi/content/abstract/67/4/380

In May’s JAACAP, a series of articles continues to work on unraveling the nature of being “at risk” as reflected in multiple dimensions. Sijtsma et al. report on a study of over 1700 boy and girls in the Netherlands. These children were enrolled in the TRacking Adolescent Individual Lives Survey (TRAILS) and evaluated at 11, 13.5, and 16 years of age. Numerous earlier studies have reported on the correlation between low heart rate and antisocial behavior in childhood and adolescence. Two mechanisms have been proposed: 1) that these youth suffer from constant baseline under arousal, which is experienced as unpleasant and 2) that sensation seeking or antisocial behavior essentially revs them up to “normal” levels. A second, competing theory is that their low heart rates reflect a level of under aroused “fearlessness” that does not adequately kick-in to prevent their misbehaving. They found that in boys lower heart rates did predict future rule breaking and aggression at age 15 and that the effect was mediated by sensation seeking at age 13.5. In girls, there were no correlations noted between low heart rate, sensation seeking, and rule breaking/aggressive behaviors in adolescents. They concluded that their data fit the sensation seeking model, but not the fearlessness model.

In a series of an additional three related articles, all appearing in JAACAP in May (a shout out to the editorial staff) Stringaris, Burke, and Barkley and their respective co-authors, report on the relationship between emotionality/emotional regulation and psychological outcome. In each study, they took a group that would be typically categorized as having a disruptive behavior disorder (ODD, ADHD) and looked at their respective research constructs for emotionality (very close to or the same as temperament), along with other components. In Stringaris’ study they found that high levels of activity and emotionality at 38 months predicted ODD at 91 months, with emotionality predicting internalizing disorders. In Burke’s study of school-age girls, the authors looked at negative affect, oppositional and antagonistic behaviors, and found that oppositional and antagonistic behavior at 5 years of age predicted conduct disordered behavior in pre-adolescence and that negative affect predicted depression for all girls, but only predicted conduct disorder for Caucasian girls. Finally, Barkley’s study looked at children with ADHD, now followed into adulthood, and whether differences there were differences in the persister and non-persisters. His group found that the persisters had far more “emotional impulsiveness” (EI), than non-persisters for the community comparison group. Additionally, they found that the severity of the EI negatively impacted many of life’s major domains, above and beyond diagnosed disorders.

The four articles are clustered because they all shed increased light on the complex nature of being at risk and may offer an opportunity for early identification and primary prevention. Boys with low heart rates might be flagged as at risk and helped to develop more adaptive behaviors and coping mechanisms. While the stability of temperamental elements has been unclear, what appears to be clear is that, as noted in the other three studies, emotional dysregulation, particularly when negative, puts one at risk. Each of the

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News Updates continued

three studies clearly defined this, albeit using their own unique terminology. This might lend itself to gentle, basic screening in the pediatric office or in the elementary school classroom. Emotional self-regulation can be enhanced through a variety of techniques (cornerstone of CBT among others), some of which lend themselves to group settings. If Gotlib’s findings on neural processing do identify a subset of at-risk children, the opportunity to intervene again presents the possibility of primary prevention. We know that the brain responds to practice (experience), why not give those who might need an additional opportunity for growth. Taking a page from educators, we might even call it an IEP or Individualized Emotional Plan where we prescribe the remediation needed to encourage mastery and minimize risk.

http://www.jaaccap.com/article/S0890-8567(10)00203-0/fulltext

http://www.jaaccap.com/article/S0890-8567(10)00106-1/fulltext

http://www.jaaccap.com/article/S0890-8567(10)00206-6/fulltext

http://www.jaaccap.com/article/S0890-8567(10)00203-0/fulltext

Prevention of Psychotic Disorders
In February’s Archives of General Psychiatry, Amminger et al. report on a successful and safe intervention for the prevention (or at least delay the onset) of schizophrenia. They enrolled 81 adolescents/young adults ages 13-25 years old who met schizophrenia prodrome criteria. Earlier studies have found that only 20-30% of patients meeting prodromal criteria will develop frank schizophrenia within the year. Since antipsychotics have a host of serious side effects, preventative treatment with antipsychotics has been seen as questionable. In Amminger’s study, they randomized patients to a double-blind intervention into either an Omega-3 polyunsaturated fatty acid group (PUFA fish oil pills) or coconut oil vitamin E/trace fish oil group. At the end of a year 4.9% of the PUFA group and 27.8% of the control group (in the expected range from earlier studies) had developed frank schizophrenia. (The differences were significant at the p=0.007 level.) PUFA also reduced overall rates of positive, negative, and general symptoms, as well as improved overall levels of functioning, all with statistical significance. Both groups had high completion rates (94%) and low rates of side effects. Given the power of the results, the low rate of side effects, and the possible multiple other benefits, prodromal schizophrenia patients clearly should start on fish oil capsules as a preventative intervention.

http://archpsyc.ama-assn.org/cgi/content/abstract/67/2/146

Consequences of Maternal Spanking
Despite professional advice from pediatricians, child and adolescent psychiatrists, and other health professionals, corporal punishment (CP) remains in use for 35-90% of children. A 2005 poll found that 72% of adults felt that “spanking was okay.” In May’s Pediatrics, Taylor et al. surveyed almost 2,500 mothers when their children were 3 years of age and then again at 5. They found that in families where mothers spanked their child two or more times per month at age 3, their children were 1.5 times more likely to be aggressive at age 5. While finding this association has been reported multiple times before, this study is the first to report controls for baseline aggression at age 3 and multiple (8) known parental risk confounders. They conclude, “The current findings suggest that even minor forms of CP, such as spanking, increase risk for increased child aggressive behavior. Importantly, these findings cannot be attributed to possible confounding effects of a host of other maternal parenting risk factors.” Simply put, parents should seek other modes of discipline; spanking is not an effective intervention.

http://pediatrics.aappublications.org/cgi/content/full/125/5/e1057
Psychologist Prescribing Legislation Defeated in Oregon

Liz DiLauro, AACAP Grassroots Advocacy Manager

This spring, the Oregon Council of Child and Adolescent Psychiatry (OCCAP) joined advocacy efforts in Oregon to successfully defeat state legislation that would have allowed psychologists to prescribe medication. The legislation (S.B. 1046) was vetoed by Governor Ted Kulongoski on April 8, 2010, who stated that “a policy change of this significance requires more safeguards, further study and greater public input than was provided during the February special session.” Oregon did not convene a regular legislative session this year, but did hold an abbreviated special session focused on the economy, job creation, and health care from February 1-25, 2010. While the governor ultimately prevented the legislation from becoming law, it did pass both the state Senate by a vote of 18-11 and the House of Representatives by a vote of 48-9, indicating strong support for the issue among members of the legislature.

In his veto letter, Governor Kulongoski proposed that the state legislature authorize a pilot program during the 2011 legislation session, when greater consideration could be given to the issue. The pilot would allow policymakers to gather data on the impact of allowing psychologists to prescribe medication, create appropriate standards and parameters, and help them to make a better informed decision on the issue.

Ajit Jetmalani, M.D., Kirk Wolfe, M.D., and Michael Franz, M.D., led OCCAP efforts over many months, joining with pediatricians to educate legislators and the governor’s office about the risks this legislation posed to children’s safety. In a final meeting with Governor Kulongoski, Dr. Jetmalani, OCCAP President, joined representatives from the Oregon Psychiatric Association, Oregon Medical Association, Oregon Board of Medical Examiners, a rural health primary care provider, as well as a psychologist, to urge the Governor’s veto. In his letter to the Governor, Dr. Jetmalani noted that the psychology lobby has “consistently demonstrated gross disregard for the complexity and risks of prescribing to children” and noted that the effect of psychologists prescribing on improving access to underserved pediatric populations is “far from clear from a safety and efficacy perspective.” He recommended that the state of Oregon “examine access issues in a systematic way rather than address these concerns with poorly researched and expedient strategies.”

As the Governor’s period of veto consideration drew to a close, Dr. Wolfe called on OCCAP’s partnership with the Oregon Family Support Network, which also contacted the Youth Move organization. Members of both organizations quickly sent a flood of messages to the Governor protesting authorization of substandard educational requirements for those who wish to practice medicine. Collaborating closely with Drs. Wolfe, Franz, and Jetmalani, AACAP’s Government Affairs Department also urged all Oregon members to take action to prevent passage of the bill. AACAP submitted a strongly worded letter to Governor Kulongoski’s office on behalf of AACAP President Laurence L. Greenhill, M.D., requesting that the legislation be vetoed.

The AACAP is concerned that allowing psychologists to prescribe medications will expose children and adolescents to inadequate care. Medical training is necessary to prescribe appropriate medications at a safe dosage level and void potentially fatal drug interactions. This is especially true when prescribing for children and adolescents. If passed, Oregon would have become the third state to allow psychologists to prescribe medication. In 2002, New Mexico passed a law authorizing certain psychologists to prescribe psychotropic medications to patients. In 2004, Louisiana also passed legislation to grant prescription privileges to trained psychologists. AACAP is working to compile materials that members can use in their advocacy efforts related to psychologist prescribing legislation, including: information about psychologist prescribing practices in states and what medical practitioners are doing to improve access to psychiatric care; a comparison chart of training requirements for professionals authorized to prescribe medication; a statement explaining the need for medical training for those prescribing psychotropic medications; and patient care examples.

If your regional organization would like to get involved in advocacy related to psychologist prescribing legislation, please contact Liz DiLauro, AACAP Grassroots Advocacy Manager at edilauro@aacap.org, 202.966.7300 ext. 107.
What I Love about
NEW YORK

Members of the Local Arrangements Committee share their favorite New York activities.

Richard Pleak, M.D.
Local Arrangements Committee Co-chair

“New York City” – the name of our city conjures up visions of a multitude of possibilities: seemingly unlimited events in entertainment, the arts, sports, even nature. For me, I love the waterways throughout the city – biking, jogging, or walking on the new and wonderful paths circumnavigating Manhattan; watching sunset on the Hudson River from any of the west side piers; or having drinks and a bite to eat on the Lightship Frying Pan, docked at Pier 66 (26th Street).

I live in NYC in part to indulge my senses in music and art. Favorite classical music haunts are Carnegie Hall, with the Mariinsky playing Mahler on the October 24th, Yo-Yo Ma playing Shostakovich and Schubert on the 26th, the Atlanta Symphony playing Ligeti and Bartok on the 30th; the Metropolitan Opera with Boris Godunov, La Bohème, and Il Trovatore that week (unfortunately, the New York Philharmonic is away on tour); and (le) Poisson Rouge, showcasing new and experimental music.

Besides the usual big art houses like MoMA and the Metropolitan Museum of Art, the art lover should visit MoMA PS-1 in Long Island City and the NewMuseum on the Bowery, designed by Pritzker prize winner SANASS, as well as explore the myriad of contemporary art galleries in west Chelsea, primarily from West 19th to West 26th Streets and between 10th Avenue and West Side Highway or 11th Ave.

And then there is eating – who doesn’t come to NYC to eat? For ultra high-end dining, the gourmet must dine at per se at Columbus Circle (make reservations at exactly 10:00a.m. exactly 2 months ahead). Vegetarians will do very well there or at the romantic Candle 79 on East 79th Street and Lexington Avenue. Forget all the Ray’s Pizza forgeries – pizza fans will have the best at Company on 9th Avenue at 25th Street or at Keste in Greenwich Village on Bleecker Street. Wine and cheese lovers should eat at Artisanal on East 32nd and Park Avenue, and shop for cheese at Dean and Deluca on Broadway in SoHo or Murray’s in Greenwich Village on Bleecker. Partake in restaurants of the Iron and Top Chefs, like Mario Batalli’s Babbo or Lupa. For cheap, delicious quintessential NYC experiences, try Thiru Kumar’s dosa cart in Washington Square Park while watching the NYU students and Greenwich Village bohemians hang out and perform. Or get burgers, fries, and frozen custard at the ever-popular and delicious Shake Shack in wonderful Madison Square Park on Broadway and 23rd Street, with its ever-changing art installations. Return to nature and go off the beaten path from Central Park at the tip of Manhattan in beautiful Ft. Tryon Park at 190th Street with its gorgeous views and Heather Garden, medieval art-filled Cloisters, and amazing New Leaf Café. With any one of these suggestions, you will have sampled the best of the best, and you’ll have had a great time being a New Yorker for at least a New York minute.

“I love NY because it’s the tops from A to Z, the architectures to the Bronx Zoo. Go to Carnegie Delicatessen and then to Carnegie Hall. And, you may want to fiddle at Lincoln Center. Top hats come and go, but when I am in NY, I feel I am on top of the world.”

~Jose Vito, M.D.
Rebecca Weis, M.D.
Member, Local Arrangements Committee

Hello, and welcome to New York! Having lived in New York City for the past 10 years, I still never get tired of just walking around the city. You will see slices of so many cultures and ways of life if you just keep your eyes open. And whether you are traveling with little ones or adults only, do not miss Central Park. The leaves on the trees around Bethesda Fountain are so beautiful in late October. Of course, there are too many great museums, restaurants, shows, etc. to count – I’ll just pass on a couple of my 7-year-old’s suggestions in honor of our field’s dedication to listening to the perspective of a child. The New Victory Theater in Times Square plays the most original shows, all intended for children (adults will have fun, too). Also, the Museum of Modern Art (MoMA) is her favorite museum, mostly because of the beautiful sculpture garden – she also highly recommends picking up a headset and going on a scavenger hunt looking for all the art with a child-friendly message! Have a wonderful stay in New York!

Yiu Kee Warren Ng, M.D.
Member, Local Arrangements Committee

I love New York City! Like a moth to the flame, NYC is a magnet for so many people fulfilling their dreams or passions. I was drawn to this amazing metropolis because of its incredible diversity, tolerance, and dynamism. My nieces and nephews visited the city for the first time last year and fell in love with the cacophony of sounds and myriad of sights that never ceased to dazzle. For those who love to travel, visiting NYC is like traveling the wonders of the world. It has something to offer everyone and every budget. My nephew loved eating dim-sum at the Jin Fong Restaurant in Chinatown and felt like he was wandering through Hong Kong on Mott and Canal Streets. My niece, Emma, the animal lover, adored her horse drawn carriage ride in Central Park from the Plaza Hotel, Central Park Zoo; and also running through the Museum of Natural History. We topped it off with a trip to the phenomenal Gorilla habitat at the Bronx Zoo. She was amazed by the urban jungle and the number of four-legged creatures in the subways! My other niece, Zoe, loved shopping, and we went to Century 21 at the site of the World Trade Center memorial and then to Broadway in SoHo. My favorite area of the city right now is the Meatpacking District and the magical elevated garden railway, the Highline. It runs uptown into the art gallery areas of Chelsea. Be sure to check out Chelsea Market, the site of the old Nabisco factory for great food and gelato!

What I love about New York is its energy—it is the most intellectually stimulating place in the world. New York stimulates the senses. I love the friendliness of the New York people.” ~Gabrielle L. Shapiro, M.D.
Reserve Your Hotel Room in New York TODAY!

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Single/Double Rate: $329/night
(available until October 1, 2010 or until the group block sells out)
When making your reservation, ask for the AACAP 2010 ANNUAL MEETING GROUP RATE to qualify for these reduced rates.

Sheraton New York Hotel & Towers
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Web site: www.aacap.org/cs/AnnualMeeting/2010

Single/Double Rate: $329/night
(available until October 1, 2010 or until the group block sells out)
When making your reservation, ask for the AACAP 2010 ANNUAL MEETING GROUP RATE to qualify for these reduced rates.

For more details about all of these hotels and to book your reservations online, visit: www.aacap.org/cs/AnnualMeeting/2010.
Travel to New York

The main ways into and out of New York include La Guardia Airport, John F. Kennedy International Airport, or Newark International Airport. For details about ground transportation from these airports to midtown Manhattan, visit www.aacap.org/cs/AnnualMeeting/2010.

Airline Discount
American Airlines is offering a 5% discount off of all fares to attendees of AACAP’s 57th Annual Meeting. Simply call (or have your travel agent call) 800.433.1790 and refer to Meeting Authorization Number A58H7AG. You can also use the discount online at www.aa.com for American Airlines/American Eagle flights only. Use the above Meeting Authorization Number as the discount code. AADVANTAGE members may accrue mileage on American Airlines for tickets purchased through this discount.

Car Rental Discount
Avis Car Rental is offering reduced rates for AACAP 57th Annual Meeting attendees. The Avis Worldwide Discount (AWD) Number is J995402. Please use this AWD number when calling Avis directly at 800.331.1600 to receive the best car rental rates available or go only to www.avis.com and enter the AWD code. NOTE: Parking in downtown New York is very expensive, and the city is very accessible to visitors without a car.

Parking at the Hilton New York
Overnight valet parking at the Hilton New York is $48/day, or $58 for a van or SUV. This includes in-and-out privileges. The valet entrance is located in the back of the hotel at W. 53rd between 6th & 7th Avenues.

Parking Discounts
The New York City Convention and Visitors Bureau has offered parking discounts for AACAP Annual Meeting attendees. Discount coupons will be available online a few weeks before the meeting and AACAP will send an e-mail about this to all attendees.

Tourism Information
For resources to help you plan other activities while in New York, visit www.nycgo.com.

ATTENTION Residents, Trainees, and Medical Students Want FREE Annual Meeting Registration?

Serve as a MONITOR for one full day of the meeting and earn free registration for the 57th AACAP Annual Meeting.

October 26-31, 2010
Hilton New York, New York, NY

For more information and to sign up to be a monitor, visit the AACAP Web site at: http://www.aacap.org/cs/AnnualMeeting/2010/monitor
LOOKING for more information about the Annual Meeting?

The preliminary program for the Annual Meeting is available at http://www.aacap.org/cs/AnnualMeeting/2010. This schedule allows you to search by topic, speaker, or day so that you can fully customize your schedule.

For details and highlights about the Annual Meeting, keep an eye out for the Registration Magazine, due to hit all AACAP member mailboxes in August; and, of course, it will be posted online!

Registration for the Annual Meeting opens August 2, 2010, for AACAP members only and August 9 for all other attendees. The Early Bird registration deadline is Wednesday, September 15, 2010. In order to ensure that you can attend all of your preferred ticketed events and save money, register online at http://www.aacap.org/cs/AnnualMeeting/2010.

SAVE MONEY! Purchase Your Audio Recordings in Advance!

Have you ever wanted to attend five Annual Meeting sessions, and they’re all at the same time? Well, now you can!

Pre-purchase the full set of Annual Meeting MP3 files at a significantly discounted price of $199. This includes over 100 sessions recorded live and made available for download. Onsite prices are higher – take advantage of this terrific value!

All Clinical Perspectives, Honors Presentations, and Symposia are included; Institutes not included. Don’t miss out on this excellent opportunity!

Select the appropriate option on your registration form to take advantage of this offer.

Please note, audio recordings do not offer CME credit.

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For more information, please contact:

Phone: 202.966.7300, ext. 104
Fax: 202.966.5894
exhibits@aacap.org
One of the goals of Project AACAP, President Larry Greenhill’s Presidential Initiative, is to register over 4,000 attendees for AACAP’s Annual Meeting, making it the largest Annual Meeting in history.

One of the best ways to achieve this goal is to encourage more AACAP members to attend. That is why we are putting the “4001 or Bust” Campaign in place to provide more options for AACAP members at the 57th Annual Meeting, October 26-31, 2010, in New York City.

Each year, the Program Committee scours over thousands of meeting evaluations and takes your feedback to heart. We have taken your input and created specific AACAP member-centric improvements for the 57th Annual Meeting.

Making the most for AACAP members we have incorporated the following upgrades:

**Members Only Registration**

AACAP Members will have the opportunity to register before the general public – from Monday, August 2 through Sunday, August 8, AACAP members have the first chance to purchase tickets to Institutes, Workshops, Clinical Consultation Breakfasts, and Special Interest Study Groups before the general public.

**Increased Workshop Sizes**

In the past, Workshops were limited to 25 attendees, and sold out quickly. This year, we increased the workshop size to 30 attendees! This allows more people to register, while maintaining the intimate learning environment designed for Workshops.

**Online New Research Posters**

With so many educational options at the Annual Meeting, attendees are not always able to see the 300+ New Research Posters presented throughout the meeting. This year, New Research Poster presenters have the option of uploading their full poster to AACAP’s Web site so that attendees can view the content after the Annual Meeting.

**Improved Online Resources**

Speaker handouts, proceedings abstracts, and customized scheduler to help you plan your schedule for AACAP’s Annual Meeting are available online! Be sure to log in to AACAP’s Program Scheduler before you leave for New York and take full advantage of these resources.


Start planning your trip TODAY!
Congratulations to our new AACAP Fellow:

Jennifer S. Saul, M.D.
Auburndale, Wisconsin

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

James R. Allen, M.D., Oklahoma City, Oklahoma
John Alston, M.D., Evergreen, Colorado
Carol Austad, M.D., Ann Arbor, Michigan
Lawrence D. Baker, M.D., Atlanta, Georgia
William R. Beardslee, M.D., Boston, Massachusetts
Manoher Rao Beareilly, M.D., Makanda, Illinois
Joseph Beitchman, M.D., Toronto, Ontario, Canada
Elissa Benedek, M.D., Ann Arbor, Michigan
Michael Bennett, M.D., Chestnut Hill, Massachusetts
Claudia Berenson, M.D., Tijeras, New Mexico
Philip J. Berent, M.D., Park Ridge, Illinois
Vinod Bhatare, M.D., Sioux Falls, South Dakota
Joseph S. Bierman, M.D., Baltimore, Maryland
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Joan Gerring, M.D., Baltimore, Maryland
Margarita Gitev, M.D., Toronto, Ontario, Canada
Ellen D. Glass, M.D., New York, New York
Martin E. Glasser, M.D., San Diego, California
Gordon Gondos, M.D., Oakton, Virginia
Alicia Gonzalez, M.D., Saint Louis, Missouri
Charles Goodstein, M.D., Tenafly, New Jersey
Harold Graff, M.D., Newtown Square, Pennsylvania
Norma Green, M.D., Brooklyn, New York
Myron Harasym, M.D., Miami, Florida
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Alexandra Harrison, M.D., Cambridge, Massachusetts
Marion Hart, M.D., Scarsdale, New York
Christopher Hodgman, M.D., Rochester, New York
Terry W. Hugg, M.D., Bellaire, Texas
Richard G. Jaecle, M.D., Dallas, Texas
Joseph J. Jankowski, M.D., Boston, Massachusetts
James E. Joy, M.D., Troy, New York
Sandra Kaplan, M.D., Manhasset, New York
Ruth K. Karush, M.D., New York, New York
Gregorio Katz, M.D., Edo De Mexico, Mexico
Andrew J. Kessler, M.D., Madison, Wisconsin
Howard J. Kaplan, M.D., Skokie, Illinois
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Bernard Langenauer, M.D., New Haven, Connecticut
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Joseph E. Lebenzon, M.D., Visalia, California
James Lees, M.D., South Yarra, Australia
Florence Levy, M.D., Randwick, N.S.W., Australia
Elizabeth Lilly, M.D., Crownsville, Maryland
Stuart L. Loeb, M.D., Pittsford, New York
John G. Looney, M.D., Crossville, Tennessee
Stephen A. Lyrene, M.D., Silverhill, Alabama
Carlos Macedo, M.D., San Antonio, Texas
Mohammad Maisami, M.D., Towson, Maryland
Michael J. Maloney, M.D., Cincinnati, Ohio
Zenaida Mata, M.D., Binghamton, New York
Robert Mckelvey, M.D., Portland, Oregon
Lenore McKnight, M.D., Lafayette, California
William McMain, M.D., Jericho, Vermont
Edward McReynolds, M.D., Houston, Texas
H. Michael Meagher, M.D., Bethesda, Maryland
Pauline Milbourn, M.D., Kingston, Jamaica
Peter J. Musliner, M.D., Cambridge, Massachusetts
Joan Stern Narad, M.D., Old Saybrook, Connecticut
Steven L. Nickman, M.D., Brookline, Massachusetts
Gary L. Nitz, M.D., Litchfield Park, Arizona
Joseph Novello, M.D., Washington, DC
Edward S. Orman, M.D., de Pere, Wisconsin
Lleni Pach, M.D., Syracuse, New York
Joanne M. Pearson, M.D., Fargo, North Dakota
P. Brent Petersen, M.D., Salt Lake City, Utah
Gary Peterson, M.D., Chapel Hill, North Carolina
Theodore A. Pettit, M.D., Piscataway, New Jersey
A. Guillermo Pezzarossi, M.D., Albuquerque, New Mexico
Bruce P. Pfeffer, M.D., Potomac, Maryland
Cynthia R. Pfeffer, M.D., New York, New York
Panom Phoungcherdchoo, M.D., Park Ridge, Illinois
Jose Pou, M.D., Ponce, Puerto Rico
Lloyd Price, M.D., Concord, Massachusetts
Diane Rankin-Miller, M.D., Saint Louis, Missouri
Kay Mayfield Reichlin, M.D., Salem, Oregon
David W. Reid, M.D., Norfolk, Virginia
Elizabeth Reynolds-Yoon, M.D., Fairfax, Virginia
Paul D. Riley, M.D., Indianapolis, Indiana
Judith Robinson, M.D., Chestnut Hill, Massachusetts
Alvin A. Rosenfeld, M.D., New York, New York
Daniel Rosenn, M.D., Wellesley Hills, Massachusetts
Pedro Ruggero, M.D., Austin, Texas
Andrew T. Russell, M.D., Los Angeles, California
William Sack, M.D., Portland, Oregon
Yusuf Salim, M.D., Scarsdale, New York
Owen Schneider, M.D., Larchmont, New York
Herbert A. Schreier, M.D., Oakland, California
Peter Schuntermann, M.D., Waban, Massachusetts
Joel Schwartz, M.D., Willow Grove, Pennsylvania
John Sealy, M.D., Torrance, California
Sandra B. Sexson, M.D., Augusta, Georgia
Kailie Shaw, M.D., Tallahassee, Florida
Robert F. Shervette, III, M.D., Augusta, Georgia
Ellen Sholevar, M.D., Narberth, Pennsylvania
John B. Sikorski, M.D., San Francisco, California
Kenneth Silvers, M.D., Los Angeles, California
Robert Slayden, M.D., Atlanta, Georgia
Mark B. Smucker, M.D., Milwaukee, Wisconsin
Joan Sobel, M.D., Brooklyn, New York
Fredric Solomon, M.D., Washington, DC
Narendra Soorya, M.D., Saint Louis, Missouri
Jeffrey S. Spector, M.D., Highland Park, Illinois
Morris Stambler, M.D., Newton Center, Massachusetts
Charles E. Staunton, M.D., Williston, Vermont
John C. Stefiak, M.D., Houston, Texas
Fredric A. Steiger, M.D., Cedarburg, Wisconsin
Militza Stevanovic, M.D., Scarsdale, New York
Charles P. Stewart, Jr., M.D., Atlanta, Georgia
Gerald Taylor, M.D., Greensboro, North Carolina
William Terry, M.D., Boise, Idaho
Margaret E. Tompsett, M.D., Summit, New Jersey
Stanley Turecki, M.D., New York, New York
Sam Tyano, M.D., Tel Aviv, Israel
Yogendra Upadhyay, M.D., Amityville, New York
Alberta Vallis, M.D., Washington, DC
Jean Van DePolder, M.D., Denver, Colorado
Jimmy Vargas, M.D., Tampa, Florida
Tom B. Vaughan, Jr., M.D., Birmingham, Alabama
Carolyn T. Villarrubia, M.D., League City, Texas
Leon Wanerman, M.D., Woodside, California
Stephen E. Warnes, M.D., Baltimore, Maryland
Lyndon Waugh, M.D., Atlanta, Georgia
Margaret Whitfield, M.D., Toronto, Ontario, Canada
John R. Wittekindt, M.D., Ann Arbor, Michigan
J. Gerald Young, M.D., New York, New York
William Young, M.D., Fountain Valley, California
Joseph Youngerman, M.D., Bronx, New York
Robert G. Ziegler, M.D., Acton, Massachusetts

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

Carmen R. Goldings, M.D., Needham, Massachusetts
Herbert J. Goldings, M.D., Needham, Massachusetts
John Halasz, M.D., Burr Ridge, Illinois
Deep Varma, M.D., Verona, Wisconsin

Stanley Greenspan, M.D.
Bethesda, Maryland

Dr. Greenspan, a pioneer and internationally renowned expert in infant psychiatry, wrote more than a dozen parenting books and developed the popular “floor time” method for reaching young children with autism and other developmental disorders.

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

Rob Grant
Director of Communications and Member Services
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Anna Eisenberg
Communication Assistant
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Nelson Tejada
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ntejada@aacap.org

You may also e-mail us at membership@aacap.org or dues@aacap.org.

Send Us Your E-mail Address
Don’t miss important and timely e-mail messages from the AACAP President Laurence L. Greenhill, M.D. If you have an e-mail address, please forward it to membership@aacap.org.
AACAP welcomes its newest members who joined between March 2010 and May 2010!

Alex Anastasiou, D.O., Las Vegas, Nevada
Sinni Bamghose, Atlanta, Georgia
Sarah Bateni, Sacramento, California
Sandra Batsel-Thomas, M.D., Cincinnati, Ohio
Harita Baxi, Albany, New York
Ellen Bettigole, M.D., Slingerlands, New York
Ish Bhalla, Toledo, Ohio
Elizabeth Bochtler, M.D., Atlanta, Georgia
Jon Wesley Boyd, M.D., Needham, Massachusetts
Tuvia Breuer, D.O., Woodmere, New York
Neil Bruce, University Heights, Ohio
Carolyn Candido, Sacramento, California
Michael T. Carpenter, M.D., Brooklyn, New York
Yufang Chang, M.D., M.P.H., Austin, Texas
Joseph Michael Cocozzella, M.D., Holden, Massachusetts
Vanessa DeSousa, Porterville, California
Hinemoa Elder, M.D., Auckland, New Zealand
Samantha Ellinwood, Sacramento, California
Alicia Garcete, M.D., Brooklyn, New York
Kendell German, Davis, California
Artha Gillis, Elk Grove, California
Reynal L. Gilmore, M.D., Atlanta, Georgia
David Arthur Graeber, M.D., Albuquerque, New Mexico
Ruth Graupera-Frain, M.D., Cleveland, Ohio
Nabila Haque, M.D., Duluth, Georgia
Matthew Hirschtritt, Cleveland, Ohio
Shannon Nicole Jap, M.D., New Albany, Ohio
Duncan Johnston, Sacramento, California
Muhammad Junaid, M.D., Chicago, Illinois
Sonia Kalaria, Brooklyn, New York
Michael Kase, M.D., Bakersfield, California
Zin Zin Khin, Sacramento, California
Barbara Kocsis, Sacramento, California
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Jensine Lee, Sacramento, California
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Richa Maheshwari, Springfield, Virginia
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Tushita Mayanil, M.D., Chicago, Illinois
James McAuliffe, M.D., Windsor, QLD, Australia
Shivani U. Mehta, M.D., Philadelphia, Pennsylvania
Erin Meierhenry, Sacramento, California
Jason Mensah, D.O., Indianapolis, Indiana
Tatjana Muhamedagic, M.D., Winnipeg, Manitoba, Canada
Robert A. Neal, M.D., Bronx, New York
Elisabeth Netherston, Houston, Texas
Casey Nevitt, Sacramento, California
Janaki Nimmagadda, M.D., Alexandria, Virginia
Nora Oberfield, New Orleans, Louisiana
Maria Oliveira, M.D., Amherst, New York
Jessica O’Neill, D.O., South Burlington, Vermont
Pallav Pareek, M.D., Troy, Michigan
Dhaval Parikh, M.D., Oklahoma City, Oklahoma
Phaedra Pascoe, Seattle, Washington
Gabriela Popescu, M.D., Palmetto, Florida
Marina Post, Houston, Texas
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Anthony Sosson, San Francisco, California
Sarper Taskiran, M.D., New York, New York
Christine Tintorer, M.D., New York, New York
Muhammad Z. Uddin, M.D., Austin, Texas
Luis Velosa, M.D., Visalia, California
Sarah Y. Vinson, M.D., Somerville, Massachusetts
Thu Huong Vu, M.D., Cincinnati, Ohio
Angela Wallace, Galveston, Texas
Kerry Wangen, M.D., Orange, California
Wai Chong Wong, Vernon Hills, Illinois
Rodney Yamaki, M.D., Aiea, Hawai’i

ERRATA

In the May/June Issue of AACAP News the pull quote at the beginning of What “Family” Means to Americans: Two Versions by Rachel Ritvo, M.D., should have read, “Most families are working under the influence of both models since the two frames are pervasive in American culture;” and the pull quote given at the opening of Hysteria Disappeared and Reappeared (and the Ugly Ducklings) by Arturo Mendoza-Lopez, M.D. was printed in error, there was no pull quote given by the author.
In 1993, Jesse Philips, brother of the late Irving Philips, M.D., AACAP president 1985-87, bestowed a gift of $70,000 to the AACAP in honor of his brother. The award was established as homage to Dr. Philips’ belief that it is better to prevent a child’s illness than to treat it. Thanks to Irving and Jesse Philips’ vision, the AACAP has honored the outstanding achievements of 16 child and adolescent psychiatrists for their bodies of work in preventing child mental illnesses.

AACAP awarded the 2009 Irving Philips Award for Prevention to Penelope Knapp, M.D., for her dedication and work for the state of California, which focused on early intervention and prevention efforts in children's mental health. For the past ten years, Dr. Knapp has engaged in systemic changes throughout the California government. As the medical director of the State of California Department of Mental Health, Dr. Knapp was able to obtain funding for prevention projects that were carried out in a variety of healthcare systems. Programs included building personnel and administrative infrastructure to serve preschool children with mental health disorders, promoting change in policy requirements for standardized screening for well child visits, screening for preconception and prenatal risk, and the recognition and treatment of postpartum and maternal depression.

Dr. Knapp also serves as Emeritus Professor in the Department of Psychiatry and Behavioral Sciences at the University of California Davis and travels widely throughout California to speak about and promote preventative, early-intervention, and other best practices in children's mental health. She has brought evidence-based medicine into public policy, introduced translational research, and built and sustained relationships outside of academia to improve preventative initiatives. Below are a few highlights of Dr. Knapp’s contributions to children's mental health:

- Guided the Department of Mental Health: Infant Preschool Family Mental Health Initiative, a pilot training and service program to extend mental health care to children 0-5 in eight California counties.
- Co-led a multi-state learning collaborative to develop and test models for improving the delivery of early child development services to at-risk children and families by strengthening primary health care services.
- Consulted on a project called Child Health and Disability Prevention Program for Pediatric Primary Care Provider Trainings on Bioterrorism and Mental Health where Dr. Knapp wrote the materials for a training package for pediatric primary care physicians to anticipate and manage psychological sequelae from disaster.

The Irving Philips Award for Prevention is also unique in that it allows the award recipient to recognize the program that he or she thinks best promotes prevention of childhood mental illness with a contribution of $2,000. Dr. Knapp selected the River Oak Center for Children, which is the Greater Sacramento area’s largest non-profit provider of behavioral health and mental health services. Every year, over 2,000 children at risk, troubled teens, and their families participate in the River Oak Center’s programs.

AACAP is proud of all Irving Philips Award winners for their exceptional achievements in the field of preventing childhood mental illnesses. The cumulative work of these dedicated child and adolescent psychiatrists is proof that Dr. Philip’s belief in preventing childhood mental illnesses is as important today as it was almost 20 years ago. The 2010 Irving Philips Award for Prevention recipient was announced in June 2010 and will present their honors presentation at the 57th Annual Meeting in New York City.

**Irving Philips Award Recipients**

<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
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<tbody>
<tr>
<td>1993</td>
<td>Albert Sonit, M.D.</td>
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<tr>
<td>1994</td>
<td>Archie Silver, M.D.</td>
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<tr>
<td>1995</td>
<td>Irving Berlin, M.D.</td>
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<td>1996</td>
<td>Syed Arshad Husain, M.D.</td>
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<td>1997</td>
<td>E. James Anthony, M.D.</td>
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<tr>
<td>1998</td>
<td>David Schaffer, M.D.</td>
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<td>1999</td>
<td>William Beardslee, M.D.</td>
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<td>2000</td>
<td>David Mrazek, M.D.</td>
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<td>2001</td>
<td>Lawrence Stone, M.D.</td>
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<td>2002</td>
<td>James C. MacIntyre II, M.D.</td>
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<tr>
<td>2003</td>
<td>N/A</td>
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<td>2004</td>
<td>Charles Casat, M.D.</td>
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<tr>
<td>2005</td>
<td>Steven Adelsheim, M.D.</td>
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<td>2006</td>
<td>Charles Zeanah, M.D.</td>
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<tr>
<td>2007</td>
<td>Harold Koplewicz, M.D.</td>
</tr>
<tr>
<td>2008</td>
<td>Michael Jellinek, M.D.</td>
</tr>
<tr>
<td>2009</td>
<td>Penelope Knapp, M.D.</td>
</tr>
</tbody>
</table>
Members & the NEWS

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

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

- **Steven Adelsheim, M.D.,** and **Hans Steiner, M.D.,** connected with Jessica Kumari from Channel One News for an article on bullying on February 23, 2010. They also connected with Erin Crawford from Parents.com for a feature on the same topic on January 13, 2010.

- **Alan A. Axelson, M.D.,** contributed to the article “Workers Fear Stigma of Seeking Mental Health Care,” which appeared in HealthDay on January 30, 2010.

- **Elizabeth C. Berger, M.D.,** connected with Stephanie Thompson for an article on talking to your children about sex on January 12, 2010. She also connected with Jeannette Moninger from Parents Magazine for an article on how much faster children are growing up today on February 4, 2010.

- **Nancy B. Black, M.D.,** and **Stephen J. Cozza, M.D.,** connected with Ellen Burke from WFUV Radio for an interview about the effects the Haiti earthquake will have on Haitian-American children in New York on January 19, 2010.

- **Michael Brody, M.D.,** appeared in an on-camera interview on January 12, 2010 with Erin Connors from Atlantic Television News to discuss why today’s youth seem to be suffering more from mental health issues than during the Great Depression. He also connected with US Magazine for an article about plastic surgery and adolescents on February 17, 2010; and with Matthew Robinson from NYC News Service for an article on the rise in sales of virtual goods in social gaming on February 18, 2010.

- **Rachel M. Brown, M.D.,** and **George A. Fouras, M.D.,** connected with Dahleen Glanton from The Chicago Tribune for an article on adoption and foster care on January 22, 2010.

- **Ian A. Canino, M.D.,** and **Sheryl Kataoka, M.D.,** connected with Jennifer Cronley from Spiritual Herald for an article on racial and ethnic healthcare disparities on February 16, 2010.


- **David Fassler, M.D.,** submitted a letter to the editor “Diagnosing Disorders,” which appeared in The Los Angeles Times on March 1, 2010; and a letter to the editor “Importance of Vaccines,” which appeared in The Chicago Tribune on March 10, 2010. He contributed to the article “Generation Rx,” which appeared in DotMed News in January 2010. He also contributed to the article “Helping Kids Cope During Crisis: What do we tell them?,” which appeared in The Boston Haitian Reporter on January 17, 2010. He also connected with Elizabeth Mechcatie from the International Medical News Group for an article about the FDA approval of olanzapine for schizophrenia and bipolar disorder for use in youths on December 15, 2009.

- **Rachael M. Fleissner, M.D.,** connected with Laura Hahn from Good Housekeeping for an article about children caring for pets on February 10, 2010.

- **Cathryn Galanter, M.D.,** and **David Shaffer, M.D.,** connected with Katie Drummond from AOL News for an article on suggested revisions for DSM-V on February 10, 2010.

- **Edward G. Hall., M.D.,** was featured in a segment profiling ‘bullying’ on News 12 New Jersey in December 2009.

- **David B. Herzog, M.D.,** was featured in the article “Model of Health,” which appeared in The Boston Globe on February 25, 2010.


- **Glenn J. Kashubra, M.D.,** and **Ian Tofler, M.D.,** connected with Cynthia Hanson from Parents Magazine for an article on kids and sports on February 4, 2010. Dr. Kashubra also connected with Ed Palladino from CBS Radio – Philadelphia for a radio interview about a local suicide case on March 1, 2010.


- **Nancy Rappaport, M.D.,** wrote the article “Speaking to Children about Suicide,” which appeared in Psychology Today on January 18, 2010.
• Eugenio M. Rothe, M.D., connected with Anahi Reynoso from Univision Network for an interview on children coming to the United States from Haiti following the earthquake on January 25, 2010.


• Fred R. Volkmar, M.D., contributed to the article “Research: Gap between Science and Practice Hindering Aide to Parents, Teachers of Autistic Kids,” which appeared in The Palm Beach Post on March 4, 2010.

• John T. Walkup, M.D., connected with Carl Sherman from Clinical Advisor for an article on the Practice Parameter on the use of psychotropic medications in children on March 9, 2010.

Congratulations!
The following speakers received the highest average ratings on evaluations from the Lifelong Learning Institute: Clinical Practice Update and Maintenance of Certification Module 6: Autism, Psychotic Disorders (Non-Affective), and Updates on Relevant Topics for Child and Adolescent Psychiatrists.

This Institute, chaired by Sandra B. Sexson, M.D., and Andrew T. Russell, M.D., was held in Seattle, Washington, March 26-27, 2010.

Linmarie Sikich, M.D. Recognizing Psychosis and Treating it Safely and Effectively (4.72 on a 5 point scale)
Jon McClellan, M.D. Early Onset Schizophrenia: Relevant Topics for Child and Adolescent Psychiatrists (4.71 on a 5 point scale)
Christopher K. Varley, M.D. Psychopharmacology: Focus on ADHD and OCD (4.60 on a 5 point scale)

Be sure to look for the latest installment of Maintenance of Certification Institutes at the 57th Annual Meeting in New York!

Kudos to the incoming and outgoing elected officers of the Society of Professors of Child and Adolescent Psychiatry:

Sandra B. Sexson, M.D., President
Gregory Fritz, M.D., President-elect
Marianne Z. Wamboldt, M.D., Secretary-Treasurer
Steven P. Cuffe, M.D., Immediate Past-president
Efrain Bleiberg, M.D., outgoing Secretary-Treasurer

Don’t Forget
“Honor Your Mentor” in the September/October issue of the AACAP News

In the September/October issue of the AACAP News, AACAP members will have the opportunity to honor their mentor(s). Whether you are a medical student, resident, active researcher or practitioner, or have retired—someone made a significant impact on your career. Even if you have done so in the past, we ask all of you to take the time to honor your mentor and tell others why they were important to you, how they influenced your life. In 100 words or less, tell us who served as your mentor. E-mail your submission to pjutz@aacap.org no later than July 26th. Don’t delay—do it today! Please include your name, affiliation (if appropriate), the name of your mentor(s), and a short testimonial or anecdote. It would be especially nice if you could contribute a photograph of you with your mentor.

Thank you,
Virginia Q. Anthony, AACAP Executive Director
Announcing Diplomates of the ABPN in Child and Adolescent Psychiatry

278 Child and Adolescent Psychiatry Diplomates received initial certification in the subspecialty of child and adolescent psychiatry in November 2009. Diplomates listed in bold lettering are AACAP Members. Congratulations to you all!
Lifelong Learning Module 4 Expires September 30, 2010

The Lifelong Learning Module 4: Schools, Forensics, Community Systems of Care, Ethics, Culture, Public Policy/Advocacy, and Updates on Relevant Topics for Child and Adolescent Psychiatrists expires on September 30, 2010. Studying this module and passing its exam will earn you 30 hours of Category 1 CME credit towards your annual Maintenance of Certification requirement.

If you currently have Module 4, be sure to complete the exam and fax it to the Assistant Director of Education and Recertification at 202-966-5894 or mail it to 3615 Wisconsin Avenue, NW, Washington, DC 20016 before September 30th. Exams received after September 30th will not be accepted for grading.

Order the module online at www.aacap.org or call Elizabeth Hughes, Assistant Director of Education and Recertification, at 202.966.7300, ext. 106. Please note, the deadline to order module 4 is Monday, August 30, 2010, in order to complete the module before the expiration date.

The deadline is rapidly approaching, so order one today!

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Reap the benefits of AACAP’s valuable educational content, including:

- Audio recordings in MP3s and CDs
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- Lifelong Learning Modules with 30 CME credits
- NEW: Speaker handouts from 56th Annual Meeting symposia

To order MP3s and CDs, visit www.softconference.com/AACAP or contact: Content Management Corporation 28524 Constellation Road Santa Clarita, CA 91355 Phone: 800.747.8069 Fax: 661.257.7288

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To access Speaker Handouts from the 56th Annual Meeting: Log in to www.aacap.org, and then go to www.aacap.org/cs/AnnualMeeting/2009 and click on the Online Program Scheduler. Questions? Call 202.966.7300, ext. 155
Thank You for Supporting the AACAP

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

Gifts Received April 1, 2010, through May 31, 2010

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Lasdon Foundation*

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Elaine Schlosser Lewis Fund
Sy Syms Foundation

$500 to $999
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J. Michael Houston, M.D. and
Kayla Pope, M.D.
Robert L. Hendren, D.O.*

$100 to $499
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Tina I. Render, M.D.

*Indicates a first-time donor to AACAP
**Indicates donor contributed a portion or all of his or her honorarium from the 2010 Lifelong Learning Institute or Annual Review Course

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

AACAP’s Campaign for America’s Kids supports innovative initiatives in education, advocacy, and research aimed at breaking the barriers to treatment for all kids.

GIVE TODAY!
Donate online at www.aacap.org.

Did You KNOW
There are almost 19,000 restaurants in Manhattan... you can eat in a different one every day for 52 years!

Do You KNOW
Times Square is named after the New York Times Building.
**CHICAGO - Rush University Medical Center**

**Outpatient Child & Adolescent Psychiatrist, Chicago, IL!**

The Department of Psychiatry at Rush University Medical Center is seeking a full-time Child & Adolescent Psychiatrist in its outpatient Child Psychiatry Program. The candidate must be board certified in Psychiatry and either BE/BC in Child & Adolescent Psychiatry. This position includes supervision of residents and child and adolescent fellows as well as direct treatment. Having interest and prior experience in working with autistic spectrum patients is preferred. This position may also allow for an administrative role that will be commensurate with experience.

The Section of Child & Adolescent Psychiatry has a strong clinical and community based program. This position will offer an excellent opportunity for clinical work, resident and fellow supervision, an administrative role and research possibilities.

This position will include an appointment at Rush University Medical School. This Salary and benefits are competitive and will be commensurate with experience. The successful candidate for this position may help define and develop the role based on individual interests. Rush University Medical Center is located just seven minutes west of the Chicago Loop. Rush is an Equal Opportunity Employer.

Please contact:
Louis Kraus, MD
Chief of Child & Adolescent Psychiatry
Rush University Medical Center
312-942-8576
Louis_Kraus@rush.edu

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**Director, Child Psychiatry Division**

The Department of Psychiatry at The Penn State Hershey Medical Center and College of Medicine is currently recruiting a board-certified child psychiatrist to provide leadership to growing division of child psychiatry. This position will also hold the University Chair in Child Psychiatry, an endowed position, at Penn State University. The Director’s responsibilities will include the development of an expanding clinical program and quality improvement initiatives. Teaching of residents, child fellows and medical students will be essential facets of the position, as well as scholarly pursuits in a specific area of expertise.

With our clinical partner, Pennsylvania Psychiatric Institute, the Department staffs a 16 bed child and adolescent inpatient unit, a child and adolescent partial hospitalization program and outpatient services at two locations. Our faculty have research interests in eating disorders, PTSD, anxiety, mood disorders, and substantial research funding in the areas of sleep, imaging and autism. Our current child/adolescent psychiatry faculty numbers 12, and we have 6 fellows in training.

The successful candidate should have strong clinical skills and an established record of scholarly achievement. An established program of research and a history of extramural grant funding are highly desirable. The successful candidate will also have evidence of effective leadership and a demonstrated ability to promote an environment that fosters productive collaboration with colleagues in psychiatry and other disciplines.

Candidates with interest and skills in this area should send a curriculum vitae and cover letter to:

Alan J. Gelenberg, M.D.
Professor and Interim Chair
Penn State Hershey Medical Center
Department of Psychiatry, H073
P.O. Box 850, Hershey, PA 17033
Phone: 717.531.8516
Fax: 717.531.6491
agelenberg@hmc.psu

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**UPCOMING EVENTS**

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

**November 24-25, 2010**
**Bangladesh Association for Child & Adolescent Mental Health (BACAMH)3rd Annual Conference and General Meeting**
Dhaka, Bangladesh
www.bacamh.org
bacamh@gmail.com

**October 18-23, 2011**
**58th Joint AACAP/CACAP Annual Meeting**
Sheraton Centre Toronto
Toronto, Ontario, Canada

**October 23-28, 2012**
**59th AACAP Annual Meeting**
Hilton San Francisco
San Francisco, CA

Penn State Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce.
Kansas
CIVILIAN CHILD/ADOLESCENT PSYCHIATRIST
Manhattan, KS

Work as a civilian Child and Adolescent Psychiatrist at Irwin Army Community Hospital and help serve those who serve our country!

Trustaff hires healthcare professionals to work as civilians at military and VA hospitals nationwide. We are currently seeking qualified Child and Adolescent Psychiatrists for immediate full-time opportunities at Irwin Army Community Hospital, which is located at Fort Riley near Kansas State University in the greater Manhattan, KS area. Working as a part of the hospital’s Behavioral Health Team, you will have the rewarding opportunity to care for active duty military and their dependents. As a company we are offering: Extremely Competitive Compensation ($270,000 - $300,000 salary); $25,000 Sign-On Bonus; $20,000 Yearly Retention Bonuses; Relocation Assistance; Yearly Continuing Education Assistance; Stable schedule allowing for great work/life balance (Monday - Friday, 7:30am - 4:30pm, minimal on-call); Long term career opportunity (5 years); Malpractice 100% Covered; Any state license is acceptable to work at this facility; Rewarding opportunity to work with active duty military and their dependents.

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

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

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

Maryland
INPATIENT PSYCHIATRISTS
Towson, MD

Sheppard Pratt is currently recruiting a child and adolescent psychiatrist or an adult psychiatrist with interest and experience providing inpatient care to adolescent and young adult patients.

Sheppard Pratt is seeking child, adolescent and adult psychiatrists with an orientation to time effective treatment, sensitivity to managed care referrals and a focus on quality care in a clinical setting with active training programs. Board certification is highly preferred. Sheppard Pratt offers flexible, competitive compensation and benefit plans and is an equal-opportunity employer.

If you are interested in advancing your professional life to the next level, we encourage you to explore this unique opportunity. Please contact Barbara Magid, Director, Professional Services, 410 938-3460 or bmagid@sheppardpratt.org

Michigan
OUTPATIENT TELEPSYCHIATRIC SERVICES

Based on a belief that high-quality, affordable, psychiatric healthcare should be available to anyone, anywhere, at anytime. InSight Telepsychiatry has pioneered a service delivery model for psychiatric evaluations. For over a decade, InSight's team of clinicians has provided services to a variety of mental health settings allowing for patient-to-provider interaction that closely replicates onsite treatment. Remotely performing over 8,000 telepsychiatry consultations annually, our expertise is readily available to meet the needs of each individual. Qualifications: Child/Adolescent/Adult Board Certified; Michigan licensed; Outpatient Telepsychiatric Services (28) hours; Patient Care evaluations, Monday-Friday; RN and NP supervision/collaboration; Benefits of Practicing Telepsychiatry with Center for Family Guidance (CFG); Quality of Life; Work from Home; Flexible Work Schedule; Paid malpractice, licensing and Credentialing; Generous Salary and Compensation package; No call; Equipment and IT support; Become a part of our growing team of Telepsychiatrists! Submit applications to: Frank Zura
Center for Family Guidance (CFG)
765 East Route 70
Marlton, NJ 08053
Phone: 856.797.4760/609.304.7504
Fax: 856.797.4779
E-mail: fzura@fgpc.com
www.in-sight.net

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To place your advertisement contact AACAP Communication Assistant
Anna Eisenberg at aeisenberg@aacap.org or 202.966.7300, ext. 154.
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- Depression
- Disaster
- Oppositional Defiant Disorder

Coming soon!
- ADHD
- Military Families
- Substance Abuse

Visit www.aacap.org for more information.
JobSource (available online at www.aacap.org) is an online recruitment tool used by employers and recruiters seeking qualified child and adolescent psychiatrists for positions around the world. This database reaches the largest group of credentialed specialists in the field.

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

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