Dear Readers,

Many of you have spent countless hours studying the complexities of common and not-so-common pediatric illnesses like acute otitis media and childhood leukemia. However, I bet that for each hour spent studying medical illnesses, you have spent far fewer hours learning about mental illnesses.

As medical students, we do not often learn how to speak to the mother who comes in desperate because her son’s hyperactivity and impulsivity gets him in trouble at home, school, and even with his friends. We are not always prepared for the teen whose recent breakup with her boyfriend has landed her in the emergency room with suicidal thoughts and a sense of desperation. And, we are not always prepared to treat the infant who, while still unable to walk, presents to the office with a broken femur and bruising.

But ADHD, suicide attempts, and child abuse are all real and pervasive problems. As pediatricians, you will encounter these challenges in as many as half of your patient visits. Not a day will go by when you won’t treat a young patient suffering from a mental illness.

What is most exciting is that as pediatricians we can do a lot to change the course of these mental illnesses, just as we can change the course of other medical illnesses! We can treat our young patients with counseling and medications, we can refer them to behavioral health specialists and psychiatrists, we can provide guidance to their parents, and we can report child abuse. Even in the most traumatic environments, children are resilient beings, and with the help of caring and compassionate pediatricians like you, we can help lead them along the road of recovery!

In this issue, we cover a myriad of topics, all connected to children’s mental health. The authors in this issue discuss topics ranging from the landmark ACE study of the late 90s, to the new DSM-5 diagnosis of disruptive mood dysregulation disorder, to a candid personal experience with an eating disorder, to a camp devoted to increasing confidence in those with severe dermatological disorders, to an interview with a child psychiatrist, to cyberbullying, and more!

Regardless of your future practice setting, I hope that you will finish this issue with at least one new tool in your tool belt that will help you work with children with mental illness.

Thank you,
Aylin Sert, MS4, Editor, AAP Medical Student News
Looks Can Be Deceiving

By Brian Smith, MD

Dr. Brian Smith is a child and adolescent psychiatrist and an Associate Professor of Psychiatry at Michigan State University School of Medicine. Below is a story which he shares often with his medical students.

Through my work with medical students in the psychiatry clerkship at Michigan State University, I am often reminded of a case that occurred over a decade ago which highlights both the importance of maintaining a wide differential and the dangers of making and acting on assumptions.

I was a resident physician in psychiatry at the University of North Carolina and AK was my patient for almost two years. She was a woman in her late 60s - a grandmother - who first presented to me with depressive symptoms. I determined, with the support of my attending physician, that she met criteria for major depression. So, AK was started on a trial of an antidepressant and given supportive psychotherapy.

She was a sweet and kind woman, and we quickly developed a therapeutic alliance. However, during the course of treatment, AK demonstrated only a partial response to the combination of medication and therapy. Her depressive symptoms never fully went into remission. Following the sudden and unexpected death of her daughter, one year into our time together, her depression worsened, and she began to exhibit suicidal thoughts. As she deteriorated, we met on a more regular basis as I addressed her grief through cognitive behavioral therapy as well as the use of multiple trials of antidepressant medications. Nothing seemed to work. Eventually, feeling that outpatient care was not improving her situation and fearing for her safety, AK was hospitalized at my same institution.

A few days into the hospitalization, a resident physician working with AK on the unit called me to collaborate and update me on her status.

She said, “You’ll never guess what we learned about your patient.”

“Don’t leave me in suspense.” I replied, “I’ve tried everything to help her and nothing seems to work.”

“Grandma’s smoking crack,” she retorted.

I was speechless. I thought back to all of my time spent with AK. Aside from a brief screening question about alcohol and illicit drugs two years prior, to which she’d said no, we had never discussed the topic again. I had neglected to include substance abuse in my differential for treatment of refractory depression, assuming that there was no way that this sweet old lady could have been a drug abuser.

After her discharge from the hospital, I met with AK again. She apologized for not sharing her secret with me and I apologized for not inquiring further.

She said that she valued our relationship and was ashamed of her crack cocaine use. Fortunately, with substance use treatment, her depressive symptoms quickly resolved. She did so well that after a few additional sessions our sessions came to an end.

Each year I explain this story to my students, as it serves as a cautionary tale that every patient deserves a wide differential, and that we should never skip over the tough questions—substance use, suicidality, abuse, sexuality, psychosis, etc.—because of our assumptions about a patient. The key to proper diagnosis and treatment is as good as the questions you ask!

Dr. Brian Smith, MD, is a child and adolescent psychiatrist and an Associate Professor of Psychiatry at Michigan State University School of Medicine.
Q. Can you describe the field of child psychiatry and why you chose it?

A. I chose to pursue medicine because I was fascinated with the brain. As a child, I loved dancing, and I was amazed by how people move. I was amazed by the different things our brain does without our knowledge. My fascination with the brain endured through medical school and residency. When I was a third year psychiatry resident on the adult wards I found myself wishing that I had met my patients earlier in their life. All of them had shared with me that their symptoms started in childhood. I thought that if I pursued child psychiatry maybe I could catch symptoms earlier. So, for me, doing child psychiatry is preventive work. It’s challenging and it keeps me on my toes. But, most importantly, it allows me to respect humanity, and that’s exciting.

Q. What paths are there towards becoming a child psychiatrist?

A. Psychiatry residency can be four years if you’re just doing general adult psychiatry, but if you’re doing child psychiatry you can fast track and do three years of adult psychiatry residency followed by two years of fellowship. You can take the longer path and do two years of fellowship after four years of general adult psychiatry residency. Or, you can do a triple board residency in pediatrics, general psychiatry, and child psychiatry. This way you would complete two residencies and one fellowship in five years.

Q. What does a normal day look like for you?

A. I wear five different hats. One hat is of a fellowship director - I manage the education and administrative aspects of the child psychiatry fellowship. Another hat is of the director of a pediatric mood and anxiety clinic. A lot of patients I see through that clinic have Medicaid and this is my way of making sure that I’m providing the service for the people who need it the most but have fewer resources. I also provide therapy and psychopharmacological treatment for private patients. My fourth hat is as the course director for the medical school’s Intro to Clinical Psychiatry course. Lastly, every Monday, I function as a consultant to pediatricians who have enrolled in the Massachusetts Child Psychiatry Access Project (MCPAP), which is a response to the shortage of child psychiatrists.

Q. How can medical students and young pediatricians best advocate for their patients?

A. Briefly, psychoeducation and social support would be the place to focus. Depression often presents as anger and irritability in children, and their demeanor tends to frustrate parents and teachers who do not necessarily equate this behavior to “depression.” Education about what depression and anxiety looks like can empower parents and create an opportunity for mental illness to be addressed. It’s a simple thing to do that medical students can practice early on. I would also recommend offering appropriate support to the school because some of these kids are quieter, so they do not always come to adults’ attention. It’s (Continued)
It’s important to have schools engage all children in a way that improves their learning capacity. Medical students and pediatricians can advocate for that by writing letters and making phone calls or attending conferences to convey a better understanding of the child’s psychological needs.

Q. What resources do you use outside of the medical field to help your patients?

A. The American Academy of Pediatrics has a great set of resources on mental health. The other website that I would recommend is the American Academy of Child and Adolescent Psychiatry’s website, AACAP.org. They have practice parameters for each condition and family fact sheets that you can print out and give to a family so they can better understand the disease. They also have a list of resources that are available in the area.

Q. Do you have any advice for budding pediatricians or child psychiatrists?

A. Fifty percent of pediatric outpatient visits are behavioral and psychiatry related, so a child psychiatry elective during medical school can be extremely helpful for future pediatric residents. An elective specifically in child psychiatry can also be informative for someone who’s interested in child psychiatry, as not every psychiatry rotation in medical school has a pediatric component.

Q. Is there anything else you’d like to add?

A. Pediatrics is all about development, stages, and ages. If we learn to look at a child from that perspective, we may be able to better focus on social-emotional development, which is vital for children to reach their potential. We need to talk more about a child’s social-emotional well being and how that ties in with their cognitive and motor development. I hope to encourage such conversations.

For more information on Child and Adolescent Psychiatry or children’s mental health resources please check out the following:

- American Academy of Child and Adolescent Psychiatry
- AAP Mental Health Initiatives
- AAP Primary Care Tools for Mental Health

Lea Sheward is a fourth year medical student at Tufts University School of Medicine.

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Each Mind Matters: 
Art Therapy on an 
Inpatient Psychiatry Unit

By Apurva Bhatt

I entered the unit balancing colored pencils, markers, bottles of paint, brushes, glitter, paper, and googly eyes in my arms. “Hi Apurva! Do you need help?” bellowed a familiar voice, as I barely managed to hold the door open with one foot and catch my balance with the other. “Sure,” I responded, “thanks Ben!” He was careful not to step beyond the unit door as he took some of the load off my hands. I entered the unit, excited to begin our art therapy session.

In March, I began a month-long inpatient neuropsychiatry elective at a long-term inpatient unit which was home to twenty-five patients, including Ben. During the days, I participated in weekly treatment team meetings which focused on the medical and behavioral therapy of each patient. I also volunteered to lead daily art therapy sessions. It was through these sessions that I felt most connected with the patients. The story of Diana, one of my patients, showed me the impact art can have on mental health. Diana was a young 22-year-old female who had been diagnosed with schizophrenia one week before she was supposed to enter college on a fully paid scholarship. She had just met her mother for the first time. During the interaction with her mother, who also suffered from schizophrenia, her mother rejected her, telling her, “I don’t know you and I don’t love you.” Shortly thereafter, Diana developed signs and symptoms of schizophrenia.

As I read through Diana’s chart, I read about how her grandmother had struggled to care for her as her symptoms progressed. Unfortunately, Diana had not responded to any medical therapy, and had failed multiple trials of medications and electroconvulsive therapy. During my month in the inpatient unit, I saw her struggle daily with her frightening visual and auditory hallucinations. I could see the physical and social toll her disease had on her. She spent most of her time in her room, often going days without showering as she believed the devil was in the water and would hurt her.

Sometimes I would make runs to “Church’s Chicken™“ to buy Diana’s favorite spicy chicken in hopes that it would encourage her to take showers. Sometimes this worked, but not always. Sometimes I would enter the unit to find Diana sitting in a corner of the hallway whispering to herself or singing Usher songs. I knew those were the days she was struggling the hardest, since she only came out of her room if her hallucinations were so frightening that she didn’t feel safe in her room. Despite all of this, Diana was a gentle soul. One day she told me that she had a “little cricket friend” who sang to her at night. I dismissed this at the time, thinking it was part of her hallucinations. The real surprise came when one day the nurse shrieked as she was gathering Diana’s dirty laundry, exclaiming that a cricket had jumped out at her! I heard Diana pleading the nurse not to harm the cricket. Instead, the nurse captured the insect in a cup and took it outside (Continued)
much to Diana’s relief.

Diana’s story resonates with me, and she helped unfold a deep level of empathy and compassion for patients with schizophrenia. However, I truly saw Diana open up when she began art therapy.

During my rotation, I had the opportunity to lead a daily art therapy group. Each day we did something different. As a group, we created recyclable bird feeders, shamrocks for St. Patrick’s Day, paper flowers, and much more. With each session, I saw the direct impact art had on helping patients. It was especially useful in developing a sense of accomplishment and self-confidence. With a stroke of a paintbrush or a splash of glitter, art therapy helped my patients express their thoughts and emotions. Unlike other aspects of their lives, their mental illness did not inhibit their creativity. Much to my surprise, Diana really took to this group. I saw how much joy she found through art and how surprised she was at her own talent. During those moments when she was concentrating on her artwork, I could tell her voices were quieter. It was a beautiful thing to see, and the moment which made me realize the therapeutic magnitude that art had on patients struggling with mental illness.

When I heard about “Each Mind Matters,” a mental health art gallery put on by my school, I decided to submit a collective piece from the patients and staff. Thus, the two pieces, “What’s inside my mind?” (Figure 1) and “What’s inside my heart?” (Figure 2) were born. Both pieces were shown in the gallery in April 2015 and were donated to a behavioral health hospital in Kansas City, Missouri. As I look back on the experiences that I had on this elective, I realize the profound impact the patients had on me, and I know that I will be a better physician because of them.

Photo: Artwork entitled “What’s Inside My Mind” created by patients at the inpatient psychiatric unit.
Camp Liberty: Empowering Youth with Severe Dermatological Conditions

By Jennifer Lee

As three camp counselors at Camp Liberty began singing Colbie Caillat’s song, “Try”, they also began to slowly take off their make-up. Their once full face of make-up was soon completely bare skin as they sang the lyrics, “Take it off...you don’t have to change a single thing.” Fellow campers at Camp Liberty watched in awe as the true meaning of the performance sunk in: we like you just the way you are; you don’t have to change a thing.

Camp Liberty is a week-long overnight camp for youth, ages 8-16, with severe dermatological conditions. The camp, based in Connecticut, first opened its doors in 2010 and is home to 150 acres of tree-filled land. Camp Liberty aims to allow campers to feel normal, to accept themselves and others for who they are, and to have fun while making new friends and trying new activities.

These activities, many of which campers experience for the first time at Camp Liberty, include swimming, high-ropes courses, movie-making, and arts and crafts, among others. Dr. Karen Wiss, one of the founders of Camp Liberty along with fellow dermatologists Dr. Richard Antaya and Dr. Dori Goldberg, says that a large part of what this camp is about is getting kids to “try things that they wouldn’t try to do otherwise” with the support of fellow campers and staff.

Dr. Wiss took the time to discuss in-depth Camp Liberty and mental health issues associated with dermatological conditions. Below is a segment from our recent conversation.

Q: How do you think dermatological illnesses can affect the mental health of children and their families?

A: Each illness is associated with different problems. For example, children with severe atopic dermatitis can be very itchy and may have subsequent sleeping issues, which impacts the quality of their lives. Those with physical deformities are frequently self-conscious about their appearance and have low self-esteem, which impacts their daily lives. Moreover, parents sometimes feel guilty that their child has a severe skin condition and believe that they are to be blamed, when that is not the case.

Q: How do you think this program affects the emotional and mental health of the children?

A: The impact is huge. For some, it is a turning point in their lives. Being at the camp helps them to increase their confidence and feel comfortable being themselves. The influence does not end once the camp is over, though. Rather, these children make friends who are facing similar issues and stay connected with them throughout the year, which is a good social support. Also, some individuals attend the camp yearly. I have seen individuals transform from being concerned first-time campers to being mentors and role models to newcomers in later years. Taking on these roles is important for them and helps them to build confidence in their own abilities.

Q: How can primary care physicians help not only the physical health, but also the mental health of these campers?

A: With dermatological conditions that can’t be treated successfully with medications, physicians should still have conversations with patients and families regarding how the conditions are affecting them. Physicians should acknowledge the difficulties and create a safe place for discussions to occur rather than dismissing the topic. The physician should offer support and resources for interested children and their families. (Continued)
**Q. What do you, other medical staff, and counselors enjoy about Camp Liberty, and what have you learned from being a part of it?**

A: For me, I enjoy seeing my patients in different settings. At the camp, it is easy to see them as people rather than patients. I have also come to better understand the family burden associated with certain conditions. For example, children with epidermolysis bullosa require daily dressing changes, which take about four hours at camp. I am in awe that their families are able to do that each day.

**Q: How do the campers describe their time at Camp Liberty?**

A: Campers really enjoy their time at Camp Liberty. Common sentiments include, “The camp is so much fun”, “This is my favorite week of the year”, “This is one week during the year when I feel completely comfortable,” and “It is rewarding to see campers have such positive camp experiences.”

Camp Liberty and the other camps under Camp Discovery are making a positive impact in the lives of all involved, including campers, medical staff, and counselors.

If you would like to donate, become involved, or learn more about this program, please visit [Camp Discovery](#).

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**My Journey into Exploring Integrative Medicine**

**By Srikruthi Kakulavarapu**

Integrative medicine is a broad term, which incorporates numerous treatments and modalities into the wellness of patient care. Dr. Andrew Weil, the Director of the Arizona Center for Integrative Medicine at the University of Arizona, defines integrative medicine as “[a] healing-oriented medicine that takes into account the whole person (body, mind and spirit), including all aspects of lifestyle. It emphasizes the therapeutic relationship and makes use of all appropriate therapies, both conventional and alternative.” As an allopathic medical student, integrative medicine was not a large part of my curriculum. Despite this, I had always been interested in learning about the realm of Eastern and Osteopathic medicine. With my own interest, especially an interest in learning about the ancient Indian treatment system of Ayurveda, I was inspired to explore the field of integrative medicine.

In 2012, I was fortunate enough to participate in the Integrative Medicine Scholars Program (IMSP) through the American Medical Student Association (AMSA). The program was a bi-weekly webinar series, which showcased different healing methods including yoga, tai chi, Ayurveda, allopathic medicine, osteopathic medicine, chiropractic medicine, acupuncture, and much more. Inspired by this course, in 2013, I became the Integrative Medicine Coordinator for AMSA and was in charge of the IMSP. During this experience, the IMSP scholars and I were introduced to the research behind integrative medicine’s use in treating chronic diseases such as cancer, diabetes, and heart disease alongside practicing self-care.

* (Continued)
In a concerted effort to make complementary and alternative medicine (CAM) a part of my learning experience once again, I made the decision to apply to Leadership and Educational Program for Students in Integrative Medicine (LEAPS), a program sponsored by AMSA which focused on well-being and self-care in 2013. Three months later, I was one of thirty medical students taking the weeklong journey. This journey took place at Kripalu Center for Yoga and Health in Lenox, Massachusetts, where we immersed ourselves into the world of CAM. Throughout this week, our group delved into rejuvenating practices like daily morning yoga and a complete vegan/vegetarian diet. Returning to the reality of medical school after that experience was tough, but I managed to incorporate some of those practices into my daily routine for a while. That is, until the weight of my daily strains once again became more apparent.

I found my way out of this stress cycle when I received a phone call one night in 2014. A dear friend I met at LEAPS was asking me to help them organize an integrative medicine conference in Chicago called Integrate Chicago. On February 7th, 2015, Integrate Chicago showcased some of the many modalities used today in CAM. Our overall goal for the conference was to create an environment for students and practitioners to sample a bit of the different medical modalities available for patients. We provided lectures in areas such as acupuncture, massage therapy, and sleep medicine, as well as an introduction on anti-inflammatory foods. We even met naturopathy students and we shared our experiences about our respective practices.

As these few experiences quickly revealed to me and my peers whom I met on my journey, we as physicians should not practice medicine within our surrounding bubble. Whether or not we choose to embrace different modalities of medicine is entirely up to us; however, being a part of the future of medicine, I believe it is important to be familiar with the various modalities available to offer to our patient populations. Perfect solutions in medicine are always evolving and at times can be elusive. Additionally, I believe that the ideals of CAM, combined with traditional treatments, may be the answer to giving patients a wholesome balance and focused healing of their well-being and advocating self-care. Personally, I have seen a positive impact of incorporating CAM practices into my own life. With my interest in pediatrics as well as CAM practices, I am excited to contribute to the future of pediatrics and pediatric research through the lens of CAM, and I urge others to explore the world of CAM as well. (Continued)
Leo Kanner’s Autism: A History

By Melissa Stone

In the early 1900s, the field of child psychiatry was virtually nonexistent and autism was not a construct. This all changed with Leo Kanner.

Leo Kanner was born in 1894 in Klekotow, Austria. He served in the Austrian army during World War I and subsequently enrolled in medical school at the University of Berlin. Though his medical school thesis focused on cardiology and he supplemented his income by writing dentistry theses on the folklore of teeth, Kanner eventually started his work as a psychiatrist at the Yankton State Hospital in South Dakota. At South Dakota, Kanner was a prolific publisher, focusing on topics such as the relationship between mental illness and the environment, neurosyphilis in Native Americans, and the Norwegian play Peer Gynt from a psychiatric perspective. Adolf Meyer, a prominent psychiatrist at Johns Hopkins, met Kanner at an annual meeting of the American Psychiatric Association and was so impressed with Kanner that he offered him a job in his department at Johns Hopkins.¹

This Austrian psychiatrist soon founded the first child psychiatry service in a pediatric hospital in 1930 at Johns Hopkins and later wrote the first comprehensive textbook on the subject in 1935. In 1943, Leo Kanner published a case series in which he describes a unique mental illness of childhood, an “autistic disturbance of affective contact.”² This publication on autism, detailing at length the unique behaviors of these children, was the first of its kind, and is how Kanner left his mark on the field of child psychiatry.

However, the medical field did not readily adapt to Kanner’s characterization of this new illness. The medical community was not in consensus as to the terminology. Kanner borrowed the term autism from Swiss psychiatrist Eugen Bleuler. Bleuler, in 1910, coined the word autism from the Latin word autisms, meaning self, for his Four A’s of schizophrenia: Autism, Ambivalence, flat Affect, and loose Associations.³ Kanner knew when he borrowed this term that there would inevitably be comparisons to the autism of schizophrenia but he concedes, “I was unable to find a concise expression that would be equally or more suitably applicable.”⁴ Over the next twenty years, there was much confusion (Continued)...
and disagreement as to what group of symptoms in children is considered autistic versus schizophrenic. Without a clear classification scheme for autism, the diagnosis was left out of the Diagnostic and Statistical Manual of Mental Disorders I (DSM-I) and DSM-II in 1952 and 1968, respectively.

However, childhood schizophrenia was in these two editions of the DSM and given a broad definition because many physicians regarded it to be “the chief functional psychosis of childhood,” effectively becoming a catchall diagnosis. Kanner was particularly disgruntled when his term transformed into what he declared to be “a pseudodiagnostic waste basket into which an assortment of heterogenous conditions were thrown indiscriminately.”

One particular disagreement regarding the symptomatology of autism was whether it was present from the very beginning of life due to genetics or developed later due to environmental influences. In particular, Bruno Bettelheim, a child psychologist at the University of Chicago and proponent of Freudian psychoanalysis, published *The Empty Fortress: Infantile Autism and the Birth of the Self* in 1967. This book promotes the idea that autism is a direct result of parents that are “refrigerated emotionally.”

Bettelheim’s beliefs on autism became wildly popular by the general public as his book was heralded by *The New York Times* and Bettelheim appeared on many television shows, soon becoming a celebrity.

In contrast, Kanner appeared to believe that autism was intrinsic to the child. He stated that symptoms started at the very beginning of life in his 1943 case series, insinuating a genetic etiology to autism. But, some scholars believe that the political climate of this time prevented Kanner from stating that he strongly believed that genetics was the cause of autism. As a Jewish immigrant from Germany who helped several hundred refugees escape the Holocaust, Kanner might have been reluctant to blame genetics for a disability, not wanting to provide support for the eugenic movement of the Nazis.

After years of “parent blaming” by physicians and the popular media, the refrigerator mother movement of the 1960s fell in the 1970s. The disability rights movement also premiered in the 1970s and deinstitutionalization took form with many autistic children brought into society. Scientific evidence supporting the notion that autism is not a consequence of parental personalities emerged in 1975. Most notably, Antony Cox and Sir Michael Rutter showed no difference in parental attributes for those with autistic children compared to those without. A few years later, Susan Folstein, in conjunction with Rutter, published the first twin-study for autism in *Nature*, showing that autism is partially, if not mostly, based on genetics.

Also in the 1970s, Sir Michael Rutter of the United Kingdom wrote many articles about autism and was able to appropriately characterize autism for both the general public and the medical community. He was able to operationalize Kanner’s case histories, leading to the addition of autism in the DSM-III in 1980. (Continued)
However, even with a working definition of autism and greater rates of diagnosis in the 1980s and beyond, autism was not immune to dispute. Andrew Wakefield’s 1998 retracted paper in The Lancet claiming a linkage between autism and the MMR vaccine erupted a public outcry against vaccines as a causative factor in autism. Most recently in the DSM-V, published in 2013, the diagnostic revision to autism spectrum disorders caused uproar as many were concerned this could lead to diminished diagnoses for those with high-functioning autism.

Controversy surrounding the etiology, definition, and treatment for autism is not a modern phenomenon – but rather, has relentlessly persisted since Kanner’s first publication on autism in 1943. Despite this, autism itself hasn’t changed. In an interview with Fred Volkmar, Director of the Yale Child Study Center and the primary author of the DSM-IV diagnostic criteria for autism, he stated “if you read Kanner’s 1943 paper and you see a child with autism, you see the same things.”

Leo Kanner relentlessly described his unique patients in his 1943 case series. In the modern world of diagnostic and billing codes, this individuality has been lost. And this problem is not unique to autism. From heart disease to kidney failure to dementia, all diagnostic criteria relate to groups, not individuals. Kanner was the first to recognize this individuality of autism and his legacy lives on today.

This article is adapted from the author’s research project through the Ethics and Humanities Pathway at the University of Miami Miller School of Medicine under the guidance of Jeffrey Brosco, M.D., Ph.D., and Kenneth Goodman, Ph.D.

References


My Struggle with an Eating Disorder

By Joshua Davis

There is needlessly a lot of stigma surrounding mental health issues. This, unfortunately, leads to delays in diagnosis and treatment, feelings of shame, and can compound already complex issues for which there is little consistently effective treatment. In an effort to combat this stigma and educate future physicians on an under-recognized subset of patients, I’d like to share my story of being a male with an eating disorder.

I was in seventh grade and on my school’s wrestling team. I was always a larger child, but within a healthy range. I found that as I lost weight for wrestling, my performance (Continued)
improved. I continued to lose weight week after week, and my coaches continued to congratulate me on making lower weight classes and winning my matches. About halfway through my eighth grade year, I was down almost 40% from the year before. I was wrestling in the lowest weight class that existed.

I felt great about winning my wrestling matches, but my weight loss became detrimental to the rest of my life. I became short of breath while climbing even a single flight of stairs. I slept over 12 hours a day and was unable to stay awake for even an hour-long class. On several occasions, I fainted at school when I stood up from a chair too quickly. Eventually my poor performance and difficulties reached my vice principal’s office. She told me that I needed a note from a doctor before I could return to school because she was concerned for my safety.

When I went to my pediatrician, it took several weeks of follow-up visits for anorexia nervosa to even be considered. A male with anorexia just doesn’t fit the stereotype. At first I really wanted to get better, but I couldn’t. Slowly, my poor performance and difficulties reached my vice principal’s office. She told me that I needed a note from a doctor before I could return to school because she was concerned for my safety.

By May of my eighth grade year, it was determined that I needed inpatient treatment due to my medical risk. Unfortunately, eating disorder treatment programs are few and far between and bed space is very limited. Moreover, only about half of programs even accept males. I ended up finding a bed out of state. It took several bouts of hospitalizations throughout high school for me to finally get on board with my own treatment.

At one point in college I was admitted to an adult medical hospital. This only occurs in rare instances, since eating disorder admissions generally take place at psychiatric hospitals and many of them focus on children. I had hit rock bottom. My first medical admission to an adult hospital as an adult really changed my outlook on my disease. The nursing staff at the hospital helped me realize that I needed to take control of my life. They could only help if I wanted it, and not helping myself would only prolong my hospitalization. After about one month on the inpatient medical unit, I was finally discharged home. That was the last time I was a patient in a hospital. It was seven years ago.

Today, I still struggle with body image and eating issues, but I have much better control and healthier outlets. I am functioning in medical school (that’s the best word I will use); I am holding a job; and I am an active member of several national organizations. I really am happy with my life right now, which is significantly better than it was when I let my eating disorder take control.

I hope my personal story will allow future pediatricians to recognize that boys are also afflicted by eating disorders. I hope this story will always be in the mind of my future colleagues. Eating disorders are commonly missed, and this is especially true for male patients. Up to 40% of eating disorders occur in males. The age of onset is getting younger and younger. I saw girls as young as 9 years old being treated with anorexia with me in the hospital. The best way to help patients with eating disorders is early diagnosis, and the best path to this is to ask screening questions while keeping a high index of suspicion.

If you are concerned for yourself or a friend, you can talk to a local medical professional or call the National Eating Disorder Association Tip Line: 1-800-931-2237.

If you would like to learn more about eating disorders, please check out the following links:

Academy of Eating Disorder Treatment Guidelines
National Eating Disorder Association

References:

Joshua Davis is a third year medical student at the Sidney Kimmel Medical College at Thomas Jefferson University.
Peter is an eight-year-old boy who experiences severe temper tantrums at the slightest provocation. These episodes have become more frequent over the past year, now occurring multiple times per week. He was initially diagnosed with attention-deficit-hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) by a previous child psychiatrist. After a recent move, Peter began seeing a new child psychiatrist who believed that his persistent irritability and episodic rage was symptomatic of pediatric bipolar disorder (BD). He was, therefore, started on a trial of lithium and risperidone, and the stimulant he had been taking was discontinued.

**Overview of the Debate:**

There has been vigorous debate over the past twenty years relating to the definition and diagnosis of pediatric BD. Amidst the debate is the unexplained forty-fold increase in prevalence of pediatric BD between the mid-1990s to mid-2000s, as well as the discrepancy between symptoms in pediatric and adult BD.

The diagnostic and statistical manual (DSM) definition of adult BD, which is characterized by episodes of mania lasting more than four to seven days, was modified for pediatric BD. For children, the classic definition of mania was deemed unnecessary for diagnosis of BD; instead, non-episodic chronic irritability, which may not deviate from the child’s baseline, was included as a diagnostic criterion. This diagnostic exemption is based on a supposition that children’s mood with BD is cycling too fast – on the magnitude of hours (Continued)
Therefore, classically the pediatric BD diagnosis is based on hyperreactivity, hyperarousal and hyperirritability. There is also great overlap between ADHD and ODD, as well. This raises several important questions that individuals such as Dr. Ellen Leibenluft of the National Institute of Mental Health (NIMH) have posed: (1) Are symptoms for pediatric BD chronic or episodic? (2) Is irritability the developmental manifestation of mania in children? Therefore, should chronically irritable children without distinct episodes of mania be diagnosed with BD? 

Advent of DMDD:

To address the aforementioned concerns, Disruptive Mood Dysregulation Disorder (DMDD) was added as a new diagnosis to the DSM V. The prevalence in children is estimated to be 3.2%. Symptoms include severe outbursts of anger, which are noted to be disproportionate in duration or intensity to the stimuli. In between outbursts children often display persistently angry or irritable mood. However, a critical characteristic of DMDD is that the symptoms manifest in multiple settings over a period of one year or more.

Prior to this new diagnosis, many clinicians may have diagnosed children with severe irritable mood as having pediatric BD; however children with constant symptoms rather than episodic symptoms may, in fact, be at higher risk for depressive or anxiety disorders later in life than true pediatric BD patients. In the previous version of the DSM, there was no diagnosis that fully captured symptoms of non-episodic irritability alone. While many patients with ODD do exhibit irritability, the diagnosis itself is based on oppositionality rather than irritability.

Furthermore, the guidelines suggest that patients who meet criteria for both ODD and DMDD should only be diagnosed with DMDD. The rationale behind this decision may be due to the classification of DMDD as a more severe disorder and, as a result, one garnering access to greater services.

Diagnostic Implications:

The diagnosis of pediatric BD ought to be used for patients who experience distinct episodes of mania, not episodes of irritability. In fact, a diagnosis of BD only muddles a child’s care because the label of bipolar I/II or bipolar NOS may be hard to remove from a patient’s clinical record. Incorporating a new category that captures more accurately the phenomenon of mood dysregulation allows for more effective treatment of the symptoms of irritability and hyperarousal that a child is feeling. Finally, this new diagnostic construct challenges the belief that chronic, severe irritability in children is necessarily a premonition for future episodes of BD.

Treatment Implications:

The issues in nosology are not merely academic distinctions. Rather, they have significant treatment repercussions. Pediatric BD is treated with medications that have a severe side-effect profile including mood stabilizers and atypical antipsychotic medications. Whereas children diagnosed with DMDD can be treated with antidepressants, such as selective serotonin-reuptake inhibitors, and stimulants. However, while there is a limited fund of clinical data supporting the specific treatment of DMDD, the basis of the medication recommendations derives from the symptoms that the patients are experiencing.

Conclusion:

Diagnosis of pediatric BD is a controversial diagnosis which, arguably, has been over-diagnosed. Chronically irritable children with exacerbations of temper outbursts may actually have DMDD instead of BD. Correctly diagnosing DMDD might encapsulate a child’s clinical course more accurately and ultimately guide better treatment options.
Overview of ACEs and Child Abuse Reporting: What Pediatricians Must Know

By Nisha Wadhwa

The Adverse Childhood Experiences (ACEs) study has gained recognition in a variety of fields ranging from healthcare services and public health to education and legislation. The study, a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente between 1995-1997, enrolled 17,000 adults from middle-income backgrounds with the intent of identifying associations between traumatic childhood experiences and long-term health outcomes.1 ACEs were grouped into ten categories, with each worth one point, and included physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, violence towards mother, household substance abuse, household mental illness, parental separation or divorce, and incarcerated household member. 2 A significant, graded relationship between the levels of traumatic stress, measured by the ACEs score, and future health indicators was identified.

Since the ACEs study, a growing number of publications have explored the effects of childhood trauma on increased risk of obesity, ischemic heart disease, fetal death, and mental illness including substance abuse disorders, major depressive disorder, and suicidality.3 This body of work has major implications for healthcare workers and how routine clinical care will be performed in the future; the practice of inquiring about ACEs in a primary care setting is becoming a routine part of taking a patient’s history.

Pediatricians can play a critical role in protecting children by recognizing and screening for child abuse and neglect. While few would argue that pediatricians have a duty to identify and report cases of suspected mistreatment, studies show that there is room for improvement among clinicians’ abilities to identify and respond to suspected abuse, especially physical trauma, which comprises 18% of all child abuse.4

One prospective observational study asked physicians to rate the likelihood that 15,000 child physical injuries were the result of abuse, and then examined the reporting behaviors in the cohort of physicians.5 They found that 27% of injuries rated “likely” or “very likely” to be

References:
due to abuse were not reported, and further exploration revealed that factors including physician familiarity with the patient’s family and low severity of the injury reduced reporting rates. These factors suggest that children who are chronically afflicted with low-level physical injuries are less likely to be correctly identified as abused. When comparing primary care physicians (PCPs) to that of child abuse specialists, accuracy in abuse assessment was comparable; however, PCPs reported 21% fewer of the correctly identified abuse cases. Moreover, research suggests that pediatric residents training in urban settings are more likely to include abuse on their differentials and consult pediatric abuse specialists more frequently than private practice pediatricians. Furthermore, behaviors surrounding reporting are not static. Pediatricians with recent child abuse education report increased confidence in their abilities to identify and manage child abuse, suggesting ongoing interventions can result in meaningful improvements.

These insights emphasize the importance of maintaining a high index of suspicion for abuse; thresholds of reporting, however, may vary on an individual basis and broach the less tangible idea of what comprises reasonable suspicion. Nevertheless, delving into these studies serves as an opportunity to review some important aspects of evaluating a pediatric patient for abuse. The AAP Section on Child Abuse and Neglect (SOCAN) recently published a clinical report, and the full text warrants careful review by providers at all levels.

The summary of these guidelines stress that physicians be alert to easily overlooked injuries, including any injury to a non-mobile infant (bruises, fractures, oral injuries), injuries in unusual locations, with a discernible pattern, affecting multiple organ systems, and importantly, in cases with inconsistent reports of mechanism. More specifically, brain imaging in infants with nonspecific signs of head injury (lethargy, vomiting, seizures), close examinations of siblings in suspected cases, and skeletal surveys for children under two with suspicious injuries are recommended components of evaluation for child abuse.

Finally, despite the logistical and emotional difficulty of addressing concerns surrounding abuse with parents of patients, CPS workers, and lawyers, it is the moral and legal responsibility of pediatricians to function in this capacity. In addition to the morbidity and mortality of physical abuse, children who survive clearly do so with increased risk of poor physical and mental health outcomes as adults.

For detailed guidelines and reporting instructions intended for clinicians, please refer to the AAP SOCAN clinical report [here](https://www.cdc.gov/violenceprevention/acesstudy/findings.html).

References:


Nisha Wadhwa is a fourth year medical student at the University of Chicago Pritzker School of Medicine.
Case Study: Improving social skills and self-esteem through focusing on core grooming and hygiene skills

By Tai Pham

Introduction:

Identity vs. confusion, which defines the core struggle of the transition from childhood to adulthood, was described by Erik Erikson as one of the crucial stages of psychological development in adolescents. During this stage, healthy adolescents, usually between the ages 12-18, continually explore their independence in a process to define their identity.

Southeast Asian teens with mental illness may experience difficulty resolving this stage for multiple reasons. Prevalent cultural beliefs hold fast to the idea that mental illness is an individual weakness due to lack of self-control; at the same time, cultural upbringing creates a sense of self that is deeply rooted in the family unit. Southeast Asian boys with mental illness may experience difficulty resolving this stage for multiple reasons. Prevalent cultural beliefs hold fast to the idea that mental illness is an individual weakness due to lack of self-control; at the same time, cultural upbringing creates a sense of self that is deeply rooted in the family unit. We present a case in which an 11-year-old Southeast Asian boy with psychosis struggles through this stage of psychological development and how targeted therapy, focusing on hygiene and grooming, may significantly improve patient engagement and serve as a springboard for discussion of identity and self-esteem.

Case Presentation:

The patient is an 11-year-old Vietnamese male who was referred to our Wellness Clinic serving Southeast Asians in the Sacramento Region. On our initial assessment, his presentation was concerning for psychosis not otherwise specified (NOS) and learning disorder NOS, which was compounded by the fact that the patient and his divorced parents, all of whom were refugees, were struggling with acculturation. His father, preferring to hold on to his cultural beliefs, refused to take part in therapy and often demonstrated concern that the staff were “Americanizing” his son. At the same time, his mother struggled with her desires to remain connected to her roots and simultaneously integrate into her newly adopted culture. The patient, on the other hand, felt marginalized at school and at home. He was unable to communicate with his parents in their native language, struggled to find motivation to participate in any cultural activities at home or within their Vietnamese-predominant community, and felt (Continued)
isolated at a school where the majority of students were Caucasian.

Comprehensive support, including weekly home visits, case management support from the mental health treatment team, and monthly follow-up with a child psychiatrist, was initiated. This led to a moderate improvement in school performance. However, the patient continued to struggle with social development and self-care. He also showed poor engagement in therapy, often sitting on his mother’s lap while staring at the floor without interaction. Despite these childlike behaviors, we noticed that the patient was transitioning through puberty, evidenced by his deepening voice and development of facial hair. An attempt was made to re-engage the patient by focusing on hygiene, grooming, and self-image without the presence of the patient’s mother. The patient was initially reluctant and refused to make eye contact with both the medical student and the psychiatrist. Initially, we laid the groundwork for the session by explaining that this session was to help him transition through the changes in his body, as he had already shown awareness of his change in voice and presence of facial hair during a previous session. We did this by first inquiring about less sensitive topics, steering clear of topics such as sexuality, and instead focused on hand washing and showering. The patient slowly opened up and even engaged in a discussion on shaving techniques. He expressed awareness of his peer’s opinions of him, and described his attempt to grow a mustache so that they would ridicule him less. His engagement improved significantly for the first time since his treatment in clinic. His eye contact progressively improved, and at the end of the session, he was even receptive to role-playing several common social encounters.

Discussion:

If given appropriate encouragement and freedom to explore safe boundaries of self, adolescents will often mature and transition into adults with a strong sense of self-worth and self-esteem. Those who struggle to receive the appropriate parental support often grow up to be less secure, with lower self-esteem, and poorer sense of self. The difficulties of adolescents become further complicated when family structure is disrupted, as evidenced in this case by divorce, with opposing strategies of acculturation. As Tobin and Friedman write, in their article outlining the specific stressors of Southeast Asian refugee adolescents, "The greatest threat to identity in refugee adolescents...is not the feeling of belonging to two cultures but the feeling of belonging to none." In cases when an adolescent doesn’t feel a cultural belonging, it may be helpful to engage the adolescent patient in something more tangible and relevant to them. This can include discussions on physical changes of puberty and using that opportunity to inquire about their view of self, values, and aspirations as a means of connecting them to their peers, who may also be experiencing the same challenges of identity.

References:


Tai Pham is a fourth year medical student at the University of California Davis School of Medicine.

Chains of Habit: A Look at Tobacco Use in Adolescents

By Jennie Thomas

“The chains of habit are too weak to be felt until they are too strong to be broken,” said Samuel Johnson, a major contributor to 18th century English literature. As adults, we have habits and patterns that define our daily lives and many of these patterns began in childhood. As a result, the pediatric period, including middle childhood through late adolescence, represents the onset of many habits and beliefs. While this includes the establishment of beneficial habits, it also includes the initiation of harmful habits as well, including cigarette smoking. (Continued)
Tobacco smoking often starts in adolescence and can have important health effects throughout life.\textsuperscript{1} According to the Surgeon General’s Report of 2012, tobacco use is a global epidemic among young people, with about 88% of current adult daily smokers reporting that they began before age 18.\textsuperscript{2} In 2009, the average age that individuals in the United States tried their first cigarette was 13-14 years old. In this country, about 4,000 adolescents between the ages of 12-17 begin smoking each day, about 80% of whom go on to become daily smokers into adulthood.\textsuperscript{2} This progression from experimentation to daily use brings to the forefront the long-lasting health implications of adolescent tobacco use.

About 33% of regular smokers who began smoking before age 18 will die prematurely from complications related to smoking.\textsuperscript{1} Of course, lung cancer is the most common cause of mortality from cigarette smoking. The cumulative risk of lung cancer in smokers approaches 30%, while the risk in non-smokers is about 1%.\textsuperscript{1} Moreover, the development of lung cancer is directly related to the age of onset of smoking, suggesting the lasting consequences of adolescent tobacco use.\textsuperscript{2} Part of this impact lies in the fact that pediatric patients are still growing and developing, and are thus more susceptible to the carcinogenic and other harmful effects of tobacco smoking when compared to adults.\textsuperscript{3} Long-term morbidity and mortality related to smoking are not limited to lung cancer. Chronic obstructive pulmonary disease, asthma, other types of cancers, and innumerable other diseases pose complications for smokers reaching adulthood. Many studies cite the fact that adolescents fail to recognize or care about the future health implications of cigarette smoking when they are young and healthy.\textsuperscript{1,2}

Nevertheless, in light of the stark health implications associated with adolescent cigarette smoking, it is imperative to target the source. Why do children and adolescents start smoking in the first place? One of the chief factors is how the child perceives smoking at a basic level.\textsuperscript{3} Growing up in a home with a parent(s) who smokes is one factor in the establishment of smoking, as “the parent-child relationship is the most significant early context in which children learn...”\textsuperscript{3} Other factors in the establishment of smoking include heavy exposure to marketing of tobacco, feelings of independence natural for the adolescent age, or associating with peers who use tobacco. Then, the reasons individuals continue smoking chiefly include addiction to nicotine, weight control, and the co-abuse of other substances, such as alcohol or recreational drugs.\textsuperscript{1}

In light of the long-term health consequences associated with smoking and the fact that the majority of smoking begins in adolescence,\textsuperscript{1} our job as healthcare providers is to encourage adolescents to avoid smoking initiation and to advocate cessation in current smokers. While a discussion of effective ways to counsel patients is beyond the scope of this article, it is important that healthcare personnel recognize just how harmful the establishment of smoking can be on the long-term health of children and adolescents.

References:


Jennie Thomas is a fourth year medical student at the University of Mississippi Medical Center School of Medicine.
Bullying and Cyberbullying Prevention: The Role of Parents and Doctors

By Amy Yu and Priyanka Saha

Roughly one fourth of children in grades 6 through 12 are bullied in school each year.¹,² According to the Center for Disease Control and the Department of Education, bullying is defined as unwanted, aggressive behavior involving a real or perceived power imbalance that is, or has the potential to be, repetitive.³ Although there is a growing awareness of bullying in the U.S., it continues to be a serious problem among today’s youth. Studies show that bullying can have lasting effects on the health and well-being of its victims and can lead to depression, sleep disorders, inattention, academic underachievement, and even suicide.⁴

Given the significant risk bullying poses to pediatric health, the students of the Pediatrics and Psychiatry Interest Groups at Harvard Medical School invited Dr. Peter Raffalli, Director of the Bullying and Cyberbullying Prevention and Advocacy Collaborative at Boston Children’s Hospital, to talk to students about bullying and cyberbullying prevention. BACPAC is a multidisciplinary team of medical professionals which includes physicians, nurses, psychologists, social workers, and pediatric resource and education specialists that act to provide resources to colleagues, patients, parents, and schools regarding bullying prevention, detection, and intervention.⁵

In his talk, Dr. Raffalli discussed the ways in which parents and doctors can identify and stop bullying. He discussed how bullying and its digital counterpart, cyberbullying, often go unnoticed by parents because most kids are reluctant to talk about them. In these cases, parents should watch for subtle changes in their child’s behavior, such as sadness, mood changes, poor self-esteem, dropping grades, or changes in sleep or appetite, which may indicate that their child is being bullied. According to Dr. Raffalli, two measures parents can take to protect their children from the harmful effects of bullying are to provide a strong, supportive family environment and ensure that their children have a good network of friends.⁶ This includes involving their children in extracurricular activities such as after-school programs, sports teams, or youth groups. Additionally, encouraging open family communication is crucial as parents can only advocate for their children once they know that bullying is taking place.

In the clinic, doctors, too, have a role in the identification and prevention of bullying through addressing it often during clinic visits. While broaching the topic can seem like a challenge, Dr. Raffalli shared a few key insights with the medical students on how to discuss bullying with pediatric patients. Indirect questioning, as opposed to direct questioning, is often more effective in eliciting information from kids.⁶

(Continued)
For example, questions such as “Are other kids nice to you at school?” and “Who do you eat lunch with at school?” are better than asking “Are you being bullied?” Given the potential for doctors to elicit such information from their patients, they can also advocate for their patients through phone calls and letters to schools to promote safer environments.

Dr. Raffalli’s talk was engaging and insightful and set the stage for identification of bullying and cyberbullying, as well as prevention. Through continued efforts of organizations like BACPAC, as well as further education and advocacy, society can work together to create a culture in which bullying no longer exists.

To learn more on BACPAC and/or bullying prevention, be sure to check out the following:

BACPAC Website
AAP’s The Resilience Project
Stopbullying.gov
Massachusetts Aggression Reduction Center

References:

Screen Time Exists: Let’s Use it to Heal
By Katelin Blackburn and Anita Knopov

Have you ever thought about social media’s potential for healing? Most people haven’t. Despite its widespread use, the use of social media as a tool for therapeutic benefit has been largely unexplored. Our generation of physicians is in a novel position. We will be the first to have grown up using social media. As digital natives, we possess a more intuitive understanding of social media than our senior colleagues, putting us in an ideal position to harness our patients’ routine use of social media for its therapeutic value. We argue that, with proper guidance, physicians have the abilities to develop social media platforms that promote healing for our pediatric patients in a variety of ways.

Children are no strangers to the world of social media and many have already turned to social media during times of illness. Injured or ill children frequently find their voices marginalized throughout the therapeutic process, and social media can provide an outlet for some of them to (Continued)
develop their own voice and have it heard. The creation of avatars can empower children to share as much of their illness as they choose, or, alternatively, to focus on portraying other aspects of themselves unrelated to their diagnosis. This interaction with social media allows the child to develop his or her own illness narrative.

Parents or caretakers of sick children also benefit from the therapeutic potential of social media. Through the use of social media, they can find communities and support networks to help them manage their child’s illness. Parents using social media may even find that it gives them a sense of control during an otherwise unpredictable medical voyage. They may find solace in the way other social media users respond to their postings one Facebook® “Like” at a time. These interactions provide ongoing validation of their child’s worth as well as their own experience. The caveat, of course, involves the challenge of balancing a parent’s need for disclosure with the privacy of their child and the child’s ownership of his or her illness narrative.

The use of social media is familiar to many physicians and trainees. The more complex question, however, involves how the medical community can use it to promote healing. To make this a reality will take active effort on our part to construct supportive web-based healing interventions, with the goal of empowering pediatric patients and their families, keeping in mind that it as important to prevent harm from misinformation as it is to provide support in innovative ways.

We also need to think beyond the status quo – that is, beyond web pages with reputable sources of information about disease processes for parents and children, beyond lists of supportive groups, and beyond professional networks and lists of specialists that parents can browse through. Although these resources are important, social media has the potential to go much further in promoting health. There are countless ways that physicians can interact with social media to positively influence their patients’ well being. Physicians can craft support groups using social media, they can send online media that support a patient’s healing, or they can create new social media platforms that allow young patients to share their stories. As future pediatricians uniquely positioned in the age of technology, it is our task to figure out how to effectively engage our young patients in a therapeutic way.

Don’t forget that the AAP suggests limiting screen time for children and adolescents! Read more about the policy here.

Katelin Blackburn (left) and Anita Knopov (right) are both second year medical students at Boston University School of Medicine.
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