This issue of *JAACAP Connect* offers a sampling of the diversity within child and adolescent psychiatry. Levy (p. 6) reviews how the default mode network, better known for its association with mind-wandering, may hold promise for the conceptualization, diagnosis, and clinical monitoring of certain psychiatric disorders in youth. Miller (p. 9) invites us to consider popular culture superheroes and their potential roles in influencing perceptions of mental illness and facilitating clinical interactions. Charoensook and Cooper (p. 13) review and discuss the literature exploring our current limited understanding of the relationship between medications used to treat attention-deficit/hyperactivity disorder (ADHD) and aggressive behavior. The authors ask, are these behaviors best thought of as medication-related adverse events? Finally, Zelenak and Getz (p. 19) provide a clinically relevant update of several new stimulant preparations for the treatment of ADHD, outlining characteristics that may prove advantageous in particular clinical scenarios.

Particularly given the summer season and its accompanying cadres of new trainees and graduates being equally welcomed into our field, I thought I'd forgo a more typical introduction and, instead, share the one that Professor Richard Livingston prepared to welcome this year's new child and adolescent psychiatry residents to the University of Arkansas for Medical Sciences. *Connect* is proud to publish his comments here for the first time. Given the breadth of our work as mental health professionals working with youth, we really do have what Livingston aptly calls "the coolest job in the world."

– Oliver M. Stroeh, MD, Editor, *JAACAP Connect*

The Coolest Job in the World

Richard Livingston, MD

My class from Little Rock Central High will celebrate our fiftieth reunion this fall. After completing college and a Teacher Corps program, I became a biology teacher at my alma mater. I had considered medical school, but frankly was tired of the student role.

One academic year, "G," one of my high-achieving sophomores from the last class hour of the day, missed a couple of days of school in the fall. I heard from another teacher that, while on a hunting trip, G had tripped on a root, accidentally discharged his rifle, and killed his best friend. The day he returned to school, he lingered after class and seemed to want to chat, volunteering to help me set up lab for the next day. Thereafter, most days for about a month, he hung around. I listened a lot. The content he shared only got really serious once or twice. He went back to his normal routines, and a couple of weeks later, he left me a note of thanks. It ended, "I know hanging around with you helped me. I have no idea how or why. But, thank you."

Being a science geek, I tried to read up on the science of helping relationships. What was readily available was kind of interesting, but seemed, well, not very scientific. But, when I decided to apply to medical school, I was already considering child and adolescent psychiatry. (By the way, G is still doing well in the world.)

The first year of medical school included full-immersion laboratories and hundreds of lecture hours. I remember three specific lectures. One was the physiology of flatus; one was the physics of coronary artery narrowing. The third was titled "Multiple Causality," by John Peters, the first child psychiatrist at the University of Arkansas for Medical Sciences (UAMS). Dr. Peters explained that, when he was trained, every psychiatric

problem was considered to be either a conditioned response (if you were a Pavlovian) or a subconscious reaction to something in the environment (if you were a psychoanalyst). Analysts ran the academic centers of American psychiatry, and the *DSM-II* listed nearly everything as a "reaction": "schizophrenic reaction," "hyperkinetic reaction," "depressive reaction." So, Dr. Peters explained, was he taught.

Then, driving one day with his three dogs in the back seat, his car was T-boned by a pickup truck that ran a stop sign. No physical injury resulted to human or dog, but the dogs, who had all had the same experience, reacted behaviorally very differently. The oldest dog showed no change at all. One became irritable and aggressive, snapping and growling readily. The third became nervous, petrified even to see a car. Dr. Peters began contemplating what might account for the differences in responses. Genetics provided a possible contributing factor. (Dr. Peters and his group went on to establish that it was possible to breed a fear of people into a line of pointer dogs, thus proving that a genetic contribution to anxiety is possible.) Similar variety in the responses of three boys who witnessed the same plane crash later that year reinforced his ideas, and he published his theory, "Multiple Causality: Toward Clarification of the Diagnostic Dilemma in Child Guidance," in Volume 1 of J. Hellmuth's 1965 edition of *Learning Disorders*. I was intrigued. Here was a confluence of biology and other facets of life, suggesting some complexity to explain how we are what and who we are.

A few years later, after general psychiatry training at Washington University in St. Louis, I was invited to become UAMS's first fellow in child psychiatry. I plunged in, got trained, and then joined the faculty, where I stayed for ten years. Another academic position followed at the New Jersey Medical School, then some years in private practice, and I am now back at UAMS.

My brain looks for, and is fascinated by, patterns, and the grander, the better. Fortunately, I also tolerate ambiguity well, and have learned to be patient. All these traits serve me well, and forty years later, I assert that I have the coolest job there is.

We may be the only medical specialty in which practitioners can truthfully assert that some of our patients end up better off when we are done than they were before a problem was present. At the very least, the child psychiatrist may help liberate young persons to develop to their fullest potentials. We may improve Inez's focus so that she can sustain enough attention to master the concept and calculation of electrochemical valence, and embrace the college-level chemistry class she was dreading. Oliver may be able to sit still for the first time and finish his meals, improving his nutrition and his dad's anxiety. Shanika finally might be able to complete her trauma narrative in therapy, and become able to walk past the neighborhood park where she was assaulted without her heart rate soaring. Jonathan might learn to reject the insults offered by his hallucinatory voice, before Doc finds just the right medication and dose to banish the voice from consciousness. Wolf may catch on to the connections between symbols and sounds, such that learning to read is now possible. Jeremiah is controlling his behaviors well enough that he only hates part of his school day, and begins to give up the notion that he is fundamentally flawed. Lucy has gone six days without making herself vomit! Small victories—progress—can be glorious.

We are not the only people who can help, certainly. But we are the ones who collect the puzzle pieces and put them together; we are the folks who understand best how the biological, psychological, social, and developmental dimensions interact, how attempts at coping can become hard-wired, for better or worse. We are the folks whose extended neurologic exam reveals that Cindy at age ten still has residual tonic neck reflex (TNR). TNR is essential for an infant: the head turns toward whichever arm extends, a reflex substrate upon which hand–eye coordination develops. But if you still do it at age ten, it can cause trouble. Trying to catch a softball, Cindy extends her arm—and her head turns reflexively, and she cannot keep her eye on the ball, and she catches poorly, and she is among the incompetent kids who are rotten at softball, which may lead to her hating sports, having a disadvantage in her social functioning among peers, and seeing herself as incompetent. We are the

folks who know what to prescribe for that problem. Occupational therapy may help her diminish the TNR; a good adaptive PE teacher may help her learn to plant herself squarely in the path of the ball so that no arm extension is required. We are the folks who can anticipate her increased risk, both statistical and logical, for anxiety in adolescence and for possible prevention—maybe even primary prevention.

We are the docs who understand Mel's struggle to sit still during worship, and how a little touch of carefully timed medication may suffice to enable him and his family to participate without the constant vigilance that once stressed them all so thoroughly.

We are the doctors whose specialty training provides us the greatest depth and breadth of understanding of all the lines of human development, how they intertwine and interact with forces both internal and external, and what might work to re-establish the good momentum of development.

An old medical school joke says the following: the surgeon knows nothing and does everything; the internist knows everything and does nothing; the psychiatrist knows nothing and does nothing; the pathologist knows everything and does everything, one day too late.

Okay, I laughed. But, the best is left out. We child and adolescent psychiatrists know important stuff, we do liberating stuff; often, I feel, we have absolutely, positively, beyond doubt, the best of all aspects of doctoring.

Welcome to the coolest job in the world.

About the Author

Richard Livingston, MD, is a professor of Child and Adolescent Psychiatry at the University of Arkansas for Medical Sciences. The department has established an award in his name for excellence in teaching residents, despite his feeble assertion that he is not dead yet.

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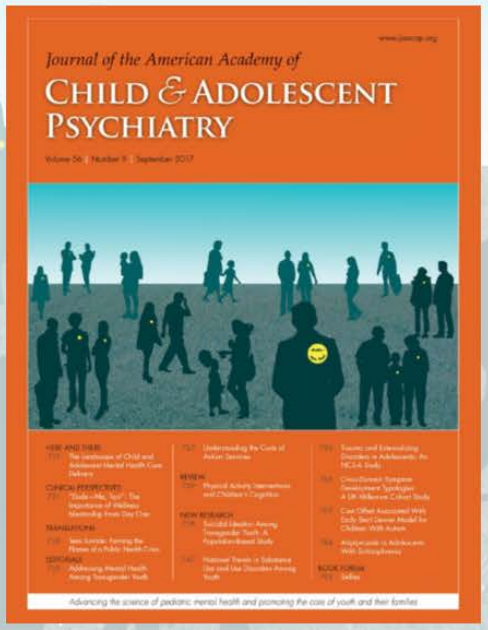

It is an axiom of English teachers that if you discard the final act, Shakespeare's comedies and tragedies are interchangeable in mood. Both types of play contain many elements of the other: *Hamlet* is full of bawdy humor, and *Much Ado About Nothing* flirts with ruined reputations and death by jilting. Indeed, the final act is where the characters plunge headlong into misery or retreat from the abyss and adjourn to a wedding (perhaps two). Misunderstandings are often the fulcrum on which the final act hinges. When these are resolved through honest conversations, the characters resume their lives happier than before; when drastic action precedes frank discussion, disaster strikes. Similarly, disclosing the fact that one is struggling can make the difference between suffering through medical training (and often beyond) and finding support, as discussed in this month's Clinical Perspectives, "Dude—Me, Too!": The Importance of Wellness Mentorship From Day One. Physician mental illness and suicide are serious problems, yet doctors struggle to seek help, mistakenly believing that doing so would show weakness or taint job prospects. Psychiatrists better than most appreciate that speaking about what is weighing on the mind tends to lighten one's load, and taking the step of admitting self-doubt, Chilton writes, will prompt others to do the same—to admit that they, too, may be struggling. The slogan "Dude—Me, Too!" is meant to prompt honest conversation about personal challenges and promote self-care and a sense of solidarity. Read the article to find out how you can support this cause, and join *JAACAP* in Clinical Perspectives 67 at AACAP's 64th Annual Meeting in Washington, DC, to hear TED-Talk style presentations from authors of recent and forthcoming installments of the Clinical Perspective series.