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## COMMITTEES

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**COVER:** Photo by Sandra Nelson, MD. A fantastic picture of wonderful giggling girls taken in Petra, Jordan. Their smiles and laughter were infectious!
MISSION STATEMENT
Mission of AACAP: Promote the healthy development of children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers.
Amended and Approved by Council, June 27, 2010

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The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy
■ Establishes and supports the highest ethical and professional standards of clinical practice.
■ Advocates for the mental health and public health needs of children, adolescents, and families.
■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.
■ Liases with other physicians and health care providers and collaborates with others who share common goals.

MISSION OF AACAP NEWS
The mission of 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.

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Ayesha Mian, MD, mian@bcm.tmc.edu Child Psychiatry Around the Globe
Timothy Dugan, MD, Timothy_Dugan@hms.harvard.edu Clinical Vignettes
Sala S.N. Webb, MD, SWebb@mcvh-vcu.edu Diversity and Culture
Arden Dingle, MD, adingle@emory.edu Ethics
Stephen Zerby, MD, zerby@upmc.edu Forensics
Rachel Ritvo, MD, rrzmd@comcast.net Psychotherapy
Sandra Dejong, MD, SDejong@challiance.org Youth Culture
Charles Joy, MD, cjjoy1@gmail.com Poetry Coordinator
Stuart Goldman, MD, Goldman, Stuart.Goldman@childrens.harvard.edu News

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AACAP EXECUTIVE DIRECTOR & PRESIDENT’S MESSAGE

From time to time, both the Executive Director and President will use this column in AACAP News to help keep the membership informed on AACAP’s programs, products, and events.

AACAP in ACTION

Heidi Büttner Fordi, CAE
Executive Director

In 2013 AACAP experienced its greatest levels of member engagement than any year before. That same momentum continues through the first quarter of 2014. We experienced record breaking numbers of attendees who travelled across the country – and around the globe, to attend AACAP’s 2013 Psychopharmacology Update in New York.

AACAP is now over 8,700 members strong! Never before have we experienced higher numbers of medical students and residents interested in the specialty and involved in AACAP activities. Through your efforts, our 2014 numbers (to date) continue to look very promising.

Our collective success is achieved through a rapidly expanding pool of energetic and enthusiastic members, like you, who are passionate about working and fighting for children’s mental health. Based on strong membership numbers and member support, we are well positioned to handle any and all challenges that may lie ahead. During this defining moment in the history of American healthcare, creating change in children’s mental health is now more possible than ever.

Every day I am humbled by the effort exhibited by both members and staff as we continue to work together in the true spirit of collaboration and cooperation. Together we embrace curiosity, welcome other points of view, and thrive on communication. As we continue to build a stronger AACAP, we fully recognize that your support and the continued trust and confidence that you place in us is the foundation of our success.

Thank you for all you do!

Advocacy in ACTION

Paramjit T. Joshi, MD
AACAP President

In the weeks leading up to our 10th Annual “Advocacy Day” (May 8-9, 2014), AACAP continues to be recognized for its leadership role on a wide range of important mental health issues. For example, earlier this month during the U.S. Senate Judiciary Committee hearing on “Solitary Confinement Assessment,” Chairman Dick Durbin (D-IL) positively referenced AACAP policy and applauded our thoughtful position. This came as no accident. Rather, AACAP sought out this opportunity to educate Congress as part of our ongoing lobbying and advocacy communication effort. We urge all of our members to do the same with their elected officials on a continual basis.

Indeed, the time is ripe for action. Right now, in Congress and statehouses nationwide, there is growing attention and interest in needed mental health reforms. We are excited that other legislators, such as U.S. Rep. Tim Murphy (R-PA), are offering a sweeping vision for comprehensive and meaningful mental health reform. These and many other efforts are opening a new dialogue as we focus on the achievable.

Laying the foundation for future advocacy success, we are excited to announce that our Director of Government Affairs & Clinical Practice, Ron Szabat, has recently filled two key positions with the hiring of Zachary Kahan as Legislative Coordinator and Bryan Shuy as Assistant Director of Grassroots Advocacy. Zach and Bryan will complete the talented Government Affairs & Clinical Practice team that includes the ongoing work of Michael Linskey, Jennifer Medicus, and Adriano Boccanelli.

Please join us in working with these talented individuals to advance our shared public and private sector advocacy agenda.

From time to time, both the Executive Director and President will use this column in AACAP News to help keep the membership informed on AACAP’s programs, products, and events.
Every July There Are New Supervisors

As another July 1st rolled around, I found myself preparing for therapy supervision with three new first-year child and adolescent psychiatry residents. As I prepared for what I wanted to say, I vowed to standardize what I said to all three. I wanted to pilot some ideas on how to start the process and to make my goals very clear from the first session. I wanted to address the barriers to teaching psychodynamic therapy, or therapies in general, head-on. I went in wanting to sell therapy to the residents and to convey what a privilege and a pleasure it is to do it. The following is a summary of what I said to my residents. Following this is a compilation of their responses.

“My goal is to teach you how to do therapy. I have two years to achieve this goal. I would like to teach you to think about therapy. I am not that interested in continually answering yes/no questions on how to do therapy, but I know I will have to do this at first.”

“There are few things that can go horribly wrong in therapy. I will stop you if you are about to do these. An example would be if you are not paying close enough attention to safety issues. Otherwise, you are free to pursue therapy as you think it should go. I only ask that you are able to provide a rationale for what you are doing. I, of course, reserve the right to question your rationale. Even if I disagree, you may maintain course if you wish, at which time I will consider it an experiment. We will see how the experiment goes and talk about the results.

“The literature shows that beginning therapists do better than they think they will. Do you know why?”

“They are interested in the patients and want to help.”

“That’s right... and full of energy. Some say that this is because the core of all therapies is the relationship, which is there regardless of one’s experience in doing therapy. I believe that the relationship is a wonderful safety net, but that therapy is more than that and that there are valuable skills and techniques that can enhance what you do. My experience is that most beginning therapists can do great therapy with some patients. Supervision makes it so you can do great therapy on a wider range of people and problems. Come to think of it, new therapists are like first parents in a way. They’re very attentive and anxious and anxious to please. Speaking of anxiety, I know that learning therapy is anxiety provoking. That is normal. If you can believe it, I am still anxious when I see new patients. I will repeat that there is little that you can do that will cause irreparable damage. Therapy, like its supervision, is a process, a relationship, the nature of which can be questioned and talked about.

“Life gets easier when you are able to catch the underlying themes. Some call these the golden threads that weave through the work. Most beginners have trouble finding these threads. Supervisors can generally help with this, as they have had more experience. Luckily, there are not that many differing types of threads, as people and what they do have many similarities. The nice thing about understanding the themes is that you then have a sense of what’s going on. That makes one less anxious. As you see the themes come up again, and they do return if you’ve identified the right ones, it reinforces that you are on to something. I liken it to New Orleans buses. They may not be on time, and you may have to wait, but they generally stick to their routes and eventually arrive. If the theme doesn’t show up, then your theme is probably wrong and you need to search for another.”

“I am going to make a few assumptions. Tell me if I’m correct. I assume that you haven’t had a lot of individual supervision like this that focuses on only a few cases.”

“You’re right.”

“I assume that what you’ve had is more management of cases.”
“Yah. We usually go over a lot of patients at a time.”

“And it’s sometimes done in groups?” I said.

“Yes.”

“And I assume that prevents you from going over the cases in detail?”

“Yes.”

“Have you ever done process notes?”

“No really.”

“Do you know what they are?”

“Sorta.”

“They are an attempt to describe what went on in the therapy, detailing what you felt was going on with the patient, you, and the relationship. I’d like you to use process notes on at least some of your patients.” I continued, “I also assume that you are not great admirers of what you call Freudian therapies?”

“That’s right. It seems to be all about penises, sex, and feces.”

I smiled and said, “I will try in the next two years to explain why that is so. Penises, sex, and feces are quite important to most people.” At that point, the residents smiled.

“I will also assume that the concepts may have been presented in ways that you felt are over your heads,” I said.

“Yes, it often didn’t make sense.”

“I take it as my job to have it make sense. Making things make sense is an important part of therapy and supervision.” I continued by asking the residents what they think of the Id, the Ego, and the Superego.

“Not much,” they replied.

“Perhaps it would help if we rename them. Do you have impulses?”

“Sure.”

“Well, let’s say that these come from the Id, but instead of Id, let’s say it comes from the lizard brain. Have you heard of that?”

“Yes.”

“Well, the lizard brain wants what it wants when it wants it.”

“Yah, I get that.”

“So let’s assume you are a male college undergrad at one of the bars, also called by some, lizard lounges, on the weekend. Do you have impulses?”

“Yes.”

“And you have specific impulse-driven goals for the night?”

“Yes.”

“Well, why don’t you just act on your impulses right then and there?”

“That wouldn’t be right.”

“Says who?”

“Society. There are laws.”

“And let’s say those laws help create the superego. Do you know there are two parts of the superego?”

“No.”

“There’s the 10 Commandments-type Superego, the “Thou Shalt Not” part, and then there’s a second part. Do you know what that is?”

“No.”

“It’s called the ‘ego ideal.’ That’s the sense of how you should be or think you should be. The Boy Scout oath and being a mensch come to mind. The ego ideal has lots to do with the values of your family and your culture. These values may differ, but each family and culture has them. So what happens when one’s lizard brain’s impulses come up against the 10 Commandments and the ego ideal?”

“There’s problems,” the resident said.

“You’re right. There is a conflict, and how are these conflicts handled?”

“I’m not sure.”

“Freud says that there are constant negotiations between the lizard brain and the superego. In reality, all sorts of things occur every weekend in those bars. Very often, the male lizards act out and bad things occur. In these cases, the impulses win out over the superego. Sometimes, mutually consented things occur. Sometimes the Superego wins and nothing happens. Freud says that it is the job of the ego to negotiate between the lizard brain’s impulses and the law. What else could we call the ego?”

“The frontal lobe?”

“Great. And what does the frontal lobe do? It is supposed to provide executive functions. And what happens to the frontal lobe when people drink?”

“The frontal lobe doesn’t work so well.”

“You’re right. Somebody once said ‘the frontal lobe dissolves in alcohol and crowds.’ Freud goes on to say that the ego tries to mediate between the lizard impulses and the law in many ways, including defenses and coping mechanisms. George Valliant categorized these defenses and noted that they vary in effectiveness. He clumped them together as to their levels of maturity. It is assumed that the sophistication of defenses used varies with many factors, including age and development and experiences. Little kids don’t have sophisticated defenses, but they have defenses nonetheless and use what they have to the best of their abilities. This lack of sophistication means that they need monitoring and support by their caregivers, as do the guys, especially the drunk ones, at the bars. This may include friends, bouncers, and/or the campus police.

“And Freud then added one more piece. He said that much of these negotiations are unconscious. As I get older, I am not quite sure of how to define this and tend to say ‘out of awareness.’ I get my confusion across by asking people to think

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about the pressure of their butt on their chair. Think about it. Were you aware of the pressure five minutes ago?”

“No.”

“Well, was that sensation unconscious, just out of your awareness, or were you just not focusing on it? Hypnosis and mindfulness deal with issues of focus.

“And what about the Oedipus complex that Freud said was so important?”

“I’m not sure,” said the resident. “I’m not sure I believe that stuff about the child wanting to sleep with his mom and that castration stuff.”

“Well, I can tell you that there’s something to it. My daughter, when she was four years old, proposed that she’d like to get married to me and that I should ditch mom. That seemed the little girl equivalent to the Oedipus. And I will say that little boys like their moms a lot and want to be with them; and that problems and conflicts arise when Mom seems to want to be with Dad more. These dilemmas do occur, whatever you want to call them, and can be important themes in therapy.

“Think about how you’d feel if your boyfriend started dating your best girlfriend.”

“That would be a mess.”

“Yes, indeed. Well, why not leave it for now that there are conflicts in which the conflict is inside the person, conflicts that involve two people, dyads, and conflicts involving three people, triads and triangles, and that I predict we will talk about all of these types of conflicts, whatever you want to call them, in our supervision.”

“Okay.”

“So trying to put this all together, Freud talks about problems being caused by these conflicts and how one’s Id, Ego, and Superego deal with them. The constant interplay of these forces and defenses are what puts the dynamic in dynamic psychiatry.

“Dynamic therapy assumes that people who are having trouble dealing with these conflicts have symptoms. The therapy is designed so that these conflicts can be understood and better compromises or solutions can be found and used. The therapy is based on the idea that symptoms make sense when one truly understands what’s going on. My goal in therapy is to help patients and their caregivers understand what’s going on so that ‘they’ can make ‘better’ or at least different decisions. I have the same goal in supervision.

“I will make a final assumption as to your training, which is you have been trained since medical school to ‘act’ and do things—to make diagnoses, to give medications, to triage, and to clear out emergency rooms. Is that right?”

“Yes.”

“And this makes it very difficult to slow down, to sit, and to ‘actively listen’ to your patients in order to help them understand. It has been my experience that it takes many residents months to make this shift in what the family therapy people call a ‘different use of self.’ We will be working on this in supervision. It is very hard to slow down and listen. The act of acting often gets in the way of our understanding our patients. My experience is that this leads to failed or stalled therapies, which in turn leads both beginning therapists and their patients to frustration and feeling bad about dynamic therapy.

“Let me end this long introduction with the sense that dynamic therapy is only one tool, a very important one I might add, out of many others. It is my favorite type of treatment. It is, however, not the only therapy I do. I often prescribe medications, do psychoeducation, parenting, couples therapy, and family therapy. These all fit comfortably for me into my understanding of the developmental-influenced, system orientation, biopsychosocial model set forth by Engel. I hope you will read his article, which was in your orientation packet. It has guided me very well for the last 30 years.

“Now, let me tell you about the last patient I saw yesterday afternoon…”

(In the next Clinical Vignettes column, I will illustrate what I have said via a clinical case presentation.)

References


Dr. Drell is past president of AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. Dr. Drell may be reached at MDrell@lsuhsc.edu.
Dialectical Behavioral Therapy (DBT) and
Dynamic Therapies: Overlap and Divergence

Blaise Aguirre, MD

All mainstream therapies have certain commonalities. They:

- Share the idea that the relationship with the therapist is a crucial part of the therapy
- Attempt to understand the patient in the patient’s world
- Attempt to make the patient feel understood
- Recognize that a patient’s belief system is understandable given the lives they have lived and the experiences they have had
- Place the responsibility of showing up to therapy and ultimately solving the problem on the work the patient does together with the therapist
- Help the patient recognize that intrapsychic conflict is part of life
- Allow the patient to see that alternative choices are an option in making a life worth living

No less is true of the therapy that I practice, dialectical behavioral therapy also known as DBT. When I started my journey into psychiatry, one that began when I was accepted into residency at Boston University, I fully intended to complete my training and enter the Boston Psychoanalytic Institute. I was awed by the ability of analysts to tie complex behaviors to unconscious drives based on early interactions between a person and the significant relationships in their past. When I finally ended up at McLean Hospital and in the presence of the great names of psychodynamic practice, I applied theory to the treatment of patients with borderline personality disorder (BPD). I found the supervision and clinical acumen of my mentors to be essential to being able to endure the turbulence of the unrelenting crises of the patients who wanted to find a way out of their suffering. Slowly, our adolescent service started to attract BPD patients from all over the United States. At the same time, DBT was being practiced in one of our classrooms and I looked upon it, bemused, as an interesting yet shallow and unsophisticated therapy that taught “skills” in a manualized approach.

But something happened on the way to the forum. The patients I was working with that were in the DBT classroom were stopping their self-destructive behaviors and suicidality far quicker than those who were not doing DBT, and certainly far quicker than those in my private practice. My patients felt understood and connected to me. They agreed with my formulations and interpretations while continuing to self-injure. They remained suicidal and had ongoing conflict with their parents and friends. My patients would get hospitalized whenever I went on vacation and expressed rage at my leaving them when I would travel to lecture, or on holiday when I went to visit my family in South Africa. I noticed that the ones who were in the DBT classroom were somehow better able to withstand my absences and seemed less volatile, less angry.

I decided to learn the treatment to see what, if anything, it could add to my dynamic practice. I attended a 5-day DBT training with colleagues. This was also in part driven by the fact that McLean was being referred adolescents with BPD at such a rate the hospital agreed to create a dedicated unit for adolescents with BPD. It was after this training that I changed my approach forever, embracing the richness of the treatment’s integration of the ancient wisdom of Buddhist and contemplative philosophy and practice with contemporary behaviorism. DBT relies on developing and exploring directly the very authentic and intense relationships with our patients by looking at observable phenomena rather than interpreting unconscious phenomena, while accepting that the behaviors have been learned through years of practice and stem from early childhood experiences. DBT states that it is behavioral change that more rapidly reverses the self-destructive behaviors than simply talking about them can. Using DBT, I remained open to a multitude of interpretations. DBT requires a sustained curiosity on the part of the therapist.

One of the first teachings in DBT that grabbed my attention was the DBT assumptions:

- Patients are doing the best they can.
- Patients want to improve.
- Patients must learn new behaviors in relevant contexts.
- Patients may not have caused all of their problems, but they have to solve them anyway.
- The lives of suicidal patients and BPD are unbearable as they are currently being lived.

Gone were ideas such as “splitting” and blaming the patient. Some colleagues angrily attributed conscious intentionality to the very pathology that brought the patient. Gone were ideas like “self-sabotage” and manipulation. New was the idea of being very curious and describing what it was that I saw. New was the idea of being direct, the idea that some self-disclosure was not only reasonable but also healing. New was the idea of using mindfulness and spirituality as a tool of healing based on emerging neuroscience that such practices could alter.

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the brain in a way that would leave the practitioner’s brain behaving like those of normal controls.

The idea that BPD is a skills deficit problem is the foundation of DBT. No person awakens each day wanting his or her life to be more miserable or complicated than it already is. If a person with BPD is not succeeding interpersonally, rather than seeing the social failures as a defense or as intentional, they are seen, from the perspective of DBT, as a deficit in ability. As such, DBT teaches people with deficits in interpersonal functioning, emotional control, distress tolerance, and mindfulness—the very skills they need.

More specifically, emotion regulation skills teach the importance of recognizing specific emotions, overcoming barriers to healthy emotions, and learning to cope more effectively when emotions become overwhelming or difficult to bear. Distress tolerance skills are taught for situations where the person with BPD cannot change in the moment. Rather than acting impulsively or self-destructively, the patient can use his/her distress tolerance skills. Interpersonal effectiveness skills teach the adolescent to maintain his/her self-respect, repair relationships, and get more of what he/she wants. Finally, mindfulness teaches paying attention to the present moment without judgment of the moment or reacting to it in ways that perpetuate suffering.

In DBT, we use transitional objects and recognize that the relationship that a patient has to his/her therapist mirrors past relationships. The difference between DBT and dynamic therapies is the use of behaviorism. Instead of just the idea of a transitional object, an actual card or little gift might be used with the clear intention of pairing an object with an important relationship. Instead of transference, we recognize a patient’s learning history, and state clearly in session that it makes perfect sense that a person would react in certain ways given his/her learning history.

Perhaps the single most useful tool in DBT is the idea of explicit validation. Simply put, validation is the recognition and acceptance of another person’s internal experience as being valid. The concept is much easier to understand than to put into practice, because as healers were are often trying to fix things. Accepting that a person is struggling and that his/her behaviors make sense given the circumstances, or that life’s problems are not so easy to solve, particularly when you do not have the skills, brings a level of compassion to the patient-therapist interaction that is, in and of itself, healing.

This column is about a personal journey. DBT has opened itself to the rigors of scientific research and withstood the test of such inquiry. It needs to continue to evolve, but I am convinced by the science. The adolescents I work with heal quicker, and I am left with the sense that if my own children were ever to suffer the ravages of BPD, I would want for them the healing power of DBT. Rather than a therapy that gives them insight, which can potentially be effective in the long term, I would want for my child the immediate relief from overwhelming and painful emotions.

Dr. Aguirre is the founding medical director of 3East at Harvard’s McLean Hospital. 3East is a residential DBT program for young women exhibiting self-endangering behaviors and borderline personality traits (BPD). He is an Assistant Professor of Psychiatry at Harvard Medical Schools. He lectures internationally on BPD and DBT, and has published several books on the subject. He may be reached at baguirre@partners.org.
DIVERSITY AND CULTURE

Historical Trauma: A Panoramic Perspective

Michelle Durham, MD, MPH, and Sala S. N. Webb, MD

“Myself, I’m one of the generations. My mother is one of the generations, wandering out there in alcoholism, and death, and murder, and domestic violence, and thinking there’s no way out. Well, there is a way out... Like I tell my children, my grandchildren, ‘You don’t have to walk that road of alcoholism and drug addiction. I walked that road. I took all those beatings for you guys. You don’t have to walk that road.’”

– Verna Bartlett, PhD, Native American elder and sexual abuse survivor

The AACAP Practice Parameter, Cultural Competence in Child and Adolescent Psychiatric Practice, was approved by the AACAP Council on April 16, 2013. The practice parameter is timely in that the demographics of the United States are changing; becoming increasingly diverse both racially and culturally. The practice parameter highlights factors associated with care of minority populations including stigma, limitations of the current science for psychiatric diagnosis, and shortcomings in treatment for these populations. Moreover, minorities face challenges around mental illness due to insufficient access to services and evidence-based treatments and higher burdens of morbidity, and possibly mortality, than Euro-Americans (Eaton 2009). Importantly, the practice parameter also addressed sources of stress for minority populations and its effect on mental health.

Over the course of this year, through this platform of the AACAP News, the Committee on Diversity and Culture will accentuate a specific element of the stress experienced by many minority peoples: historical trauma. Historical trauma, sometimes referred to as “multigenerational trauma,” is the “collective emotional and psychological injury, both over the life span and across generations, resulting from a cataclysmic history that occurs as a result of genocide and other significant abuses” (Brave Heart 2011). When this past trauma is unacknowledged or is not resolved, it gets passed on to the next generation and creates psychological loss. The response to historical trauma can manifest in a variety of ways—depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, substance use, and difficulty recognizing and expressing emotions (Osher 2011).

Historical trauma has been experienced by many. Some examples include First Nations People, Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants, the survivors of slavery and their descendants, and other exploited and persecuted populations. Native American and Alaska Native communities experienced traumas such as displacement, forced assimilation, and suppression of their language and culture. Historical trauma for Asian American families is closely linked to their immigration experiences, such as the internment of Japanese Americans during World War II and the treatment of the Hmong people after the Vietnam War. Historical trauma for African American communities and families in the United States is rooted in the forced immigration of their ancestors through slavery. Of note, this historical trauma for African Americans in this country did not end with the abolition of slavery; as segregation, racial discrimination, social abuse, medical exploitation and violence targeting African American people continued to affect their lives (Osher 2011). Many Latinos, like African Americans, were forced to immigrate to the United States as indentured servants or slaves. Latino families from South and Central America, Mexico, and the Caribbean experienced the trauma of public executions, kidnappings, and assassinations perpetrated by rebels or sanctioned by governments in power, law enforcement, or the military (Osher 2011).

According to the Substance Abuse and Mental Health Administration’s (SAMSHA) GAINS Center for Behavioral Health and Justice Transformation, historical trauma can manifest itself as
1) Historical Unresolved Grief: grief that has not been adequately expressed, acknowledged, or otherwise resolved;
2) Disenfranchised Grief: grief when loss

continued on page 72
cannot be voiced publicly or that loss is not openly acknowledged by the public; or 3) Internalized Oppression: traumatized people may begin to internalize the views of the oppressor and perpetuate a cycle of self-hatred that manifests itself in negative behaviors. Emotions such as anger, hatred, and aggression are self-inflicted, as well as inflicted on members of one's own group.

Brave Heart (2011) offers a historical trauma intervention model which includes four major community intervention components: 1) confronting the historical trauma, 2) understanding the trauma, 3) releasing the pain of historical trauma, and 4) transcending the trauma. She hypothesizes that the intervention model increases awareness of trauma, provides relief from the shared effects of the trauma, and collective healing creates a positive group identity and commitment to community. “Connecting the past with the present is inherent in many cultural traditions. Historical trauma theory contextualizes ‘time and place.’ It validates and aligns itself with the experiences and explanatory models of affected populations and recognizes issues of accountability and agency. It creates an emotional and psychological release from blame and guilt about health status, empowers individuals and communities to address the root causes of poor health, and allows for capacity building unique to culture, community and social structure” (Sotero 2006).

We of the Diversity and Culture committee invite you to join the discussion on this important issue. We hope that it will add a new dimension to the perspective through which we view not only our patients and their families, but also ourselves.

References

Dr. Durham is chief resident, Solnit Track, and clinical fellow, Child and Adolescent Psychiatry at Yale Child Study Center/Albert J. Solnit Children’s Center. She may be reached at michelle.durham@yale.edu.

Dr. Webb is assistant professor in the Department of Psychiatry at Virginia Commonwealth University. She is coordinator of the Diversity and Culture Column. She may be contacted at sswebb@vcu.edu.
YOUTH CULTURE

About Minecraft

Nicholas Putnam, MD

Last summer, my grandson and I spent a week in the Pacific Northwest. After a rafting trip down the Deschutes River, loaded with flora and fauna and an occasional rapid, I asked our host’s ten-year-old son how he enjoyed the day. He told me his day initially had gone well, but... “after we got home, I was trying to build a house. It was a fairly nice house with a portal in it. In the other room there was a second portal but the wall in between them kept catching on fire. So I broke portal #1 but it kept catching on fire...it was because the second portal was made of lava. I was nervous when it caught fire because I didn’t want my house to burn to the ground because I worked hard on it.”

A budding psychosis in middle childhood? Autistic spectrum disorder? No, it was simply the allure of Minecraft. On that day, his experience on a computer screen had trumped the great outdoors.

We hosted a couple of young visitors from Europe this summer, friends of the family coming to improve their English. One of the boys, 12, came with a note for our host’s ten-year-old son. “I want to try Minecraft!” He became an immediate hero to my six-year-old grandson. He knew how to install “mods,” which add valued features to the game, and he knew all the cool Minecraft videos on YouTube (This year alone Minecraft sold over 10 million copies for computers, and according to Wikipedia, by May 2012, over 4 million Minecraft-related YouTube videos had been uploaded). The 12-year-old could be found past midnight working feverishly to avoid a lava flow while “mining” in a dark tunnel. The other boy was equally glued to video screens (whether on a mobile phone, iPad, or computer) but had no interest in Minecraft. He preferred puzzles or action games usually based on sports.

Recently, a number of my patients have attempted to devote their entire psychotherapy session to sharing their experiences on Minecraft. The parents, of course, had a different agenda, which was of little interest to the boys who wanted to talk about their latest accomplishment, frustration, discovery, or increasing knowledge of the game (I have yet to meet a girl who is so devoted to Minecraft, although they probably exist). These youngsters share their knowledge with a great deal of pride, in the way some kids share knowledge about their favorite sports teams or superheroes, or, sadly, less common today, their knowledge of aspects of the natural world, for example rocks, insects, or reptiles.

Minecraft was created by Swedish programmer Markus Persson, or “Notch” as my grandson and his friends reverently refer to him. It has been available for over four years. In some ways, it is like a virtual version of Legos. It has a distinctive, cubical 3D look with a nearly limitless variety of textured blocks. Players can construct houses and landscapes, much as they might with a Lego set. One “mines” for materials that are used to “craft” (hence the name) various objects, including structures, tools, armor, and weapons. Some of these creations can be impressive. The game provides a world that a player can explore and modify. My grandson chooses to play with the game set to the “creative” mode. He calls it the “peaceful mode.” With this setting, the players have unlimited resources and do not have to worry about the health or the hunger of their avatar. Of course, a few youngsters become so involved that they neglect their own needs for sleep, nutrition, and hygiene.

Somewhat older players prefer the “survival” mode. There they must deal with dangerous adversaries, among them Endermen who “may turn hostile when provoked,” according to Minecrafwiki. In survival mode, players have access to better resources but must maintain their “health,” which is always in jeopardy from a variety of hazards including monsters, falls into lava or water, and other catastrophes. For players who want a bigger challenge, there is the “hardcore” mode, which is the survival mode set to a higher level of difficulty. This mode will also delete all that the player has accumulated and created in case of “death.” When this happens one must start anew, and hours, or in some cases, days of work are lost.

We need not be surprised that such games are powerfully attractive to some of our young patients. Of course there is the visual appeal. More importantly, we know that middle childhood is marked by Erikson’s stage of industry versus inferiority. It is a time to take pride in competence and accomplishment. This self-confidence helps prepare the child for adolescence. As Napoleon Dynamite put it, in the film of the same name, “Girls only want boyfriends who have great skills.” Of course, sports or music skills will certainly be more important continues on page 74
than videogame skills in the eyes of girls as these boys get older, but that does not concern them yet. Video game skills are likely also to be devalued by parents and teachers. Nevertheless, these boys are quite proud of their comprehensive knowledge of the incredibly intricate details of Minecraft. It has been argued that Minecraft is also teaching children important skills in computer-animated drawing, which could lead to a career in architecture or interior design. Adults may prefer that children gain competence in areas with more of an obvious benefit. When children participate in scouting, sports, art, animal husbandry, or martial arts programs, for example, they are gaining knowledge that many feel may be of use to them and society in the future. To some extent, this is a question of values and, to be fair, I have not found much use for the various knots I learned to tie years ago as a Boy Scout. However, I did learn to tie these knots in the company of real peers and adults, and tested them on camping trips.

Thus, we can congratulate our patients on the knowledge and skill they have achieved with Minecraft or similar games, in contrast to many of the so-called “mature” games filled with often gratuitous violence. It is a good practice for parents also to show an interest in their child’s video game play. There is no harm in praising a child’s efforts to, for example, design a cool home in an interesting landscape while dealing with adversity, all on a computer screen. Parents sometimes fear that showing such an interest might encourage a child’s “addiction” to these games. In fact, there are cases where it would not be inappropriate to use the word “addiction” to describe a child’s dependence on a particular video game. These games can provide seductive escapes from a boy’s ordinary life. However, in most cases, parents can be reassured that there are some healthy aspects to their son’s interest in the game and in his pride of knowledge about the game.

As an advocate for a particular patient, however, we must assess whether his investment of time and energy in Minecraft has become a problem. Is this time spent in the game harmful in some way to the boy’s healthy development? Is he playing Minecraft when he should be sleeping, doing homework, getting exercise, or involved socially with family or peers? Does he become irritable when he does not have access to the game? Does the child have a psychiatric disorder that relates to the game obsession? Has Minecraft become a “highly restricted, fixated interest that is abnormal in intensity or focus,” as the DSM-5 puts it? On hand-held devices, these games often provide parents a respite from interaction with their children, for example, in restaurants or during travel. This can be helpful for busy parents, as long as they do not come to rely excessively on the distraction of the game and abdicate their responsibility to interact with and socialize with their children. Certainly, it is important that parents set limits on the time children spend in front of all “screens,” including television. To do so successfully, they must make available healthy, attractive alternatives. They need to get their children playing outdoors or in the gym. Each case is different and requires the wisdom of the clinician to properly advise parents.

Having some knowledge of these games is an important step in evaluating their impact on our patients.

Dr. Putnam has practiced child and adolescent psychiatry for more than thirty years in Encinitas, California; he serves on the clinical faculty at the University of California, San Diego, where he teaches child psychiatry fellows. Dr. Putnam may be reached at dr.nick@drnickputnam.com.
ETHICS COLUMN

School Daze*

Adrian Sondheimer, MD
AACAP Ethics Committee

The latest case to come the way of AACAP's Ethics Committee, submitted by an AACAP member, derives from work in school consultation. As readers have been advised in the past, please review the below vignette, then stop reading, ask of yourself what you believe to be the salient presenting ethical conflicts (if any), consider how you would choose to resolve them, and write your responses on paper or electronically. Then, to obtain a sense of how the AACAP's Ethics Committee members and two members of AACAP's School Committee responded, resume reading.

VIGNETTE: I am a child and adolescent psychiatrist, employed and salaried by a general hospital in the Southwest, working in one of my hospital's mental health clinics that is located inside a public school. Direct services are provided to students attending both mainstream and special education classes at this site. The students' families are billed for these services by the hospital, and the hospital is paid by the families' insurance coverage. Separately, the hospital receives monies directly from the school system covering the salaries of several non-physician clinical staff working in the clinic, and the premises are used “rent-free” by the hospital personnel at the school.

Recently, following my psychiatric evaluation of a student, I felt the child required out-of-district placement in a therapeutic day school. The relevant administrative school personnel disagreed, primarily, I suspect, because of the expense the school district would incur were this recommendation followed. The parents of the child chose to address the school system's opposition in court by filing suit to obtain this recommended placement. The chief administrator of the clinic, my supervisor, advised me to not cooperate with or assist the lawyer for the family in this litigation. Several other similar cases have arisen at the clinic with the same advice provided to me and fellow clinicians in those instances.

I am seeking input from AACAP's Ethics Committee because I am experiencing conflicts of interest. On one hand, I understand the need for the clinic and hospital to maintain good relations with the school's administration in order to continue to provide needed services for many students in a highly desirable, if not ideal, setting and arrangement. But, on the other hand, it seems to me that my primary ethical obligation is to my patient, to advocate for his or her best interests to the best of my ability. Simultaneously, I prefer to remain in the good graces of my supervisor, and not jeopardize my position and job at the clinic and hospital. Please help me out.

RESPONSE: In a uniform response, thus differing from other cases that have come the way of the Ethics Committee, the 13 Committee members unanimously favored protecting the best interests of the individual child, thus suggesting that the child and adolescent psychiatrist (CAP) hold fast to the carefully considered opinion at which (s) he had arrived. Further, (s)he should not revise or modify that opinion in the face of school administration or supervisory opposition. Pursuing the best interests of the child in this fashion, and advocating for the child's needs, is clearly supported by the ethical principle of beneficence. Beyond that initial stance, several members suggested that practitioners should not make explicit recommendations for placements in specific specialized classes or schools, but rather they should delineate the educational and behavioral needs, and the supports, services, and interventions the child might require. This would leave it to the school system to adequately match the educational setting to those needs. Similarly, several individuals suggested that criteria for differing placement recommendations be established, by the CAP consultants and school personnel, well in advance of their application to a particular student.

Having said this, the members did not ignore the importance of maintaining the hospital clinic operation in the school setting, and the necessity for maintaining good collaborative relations with school personnel. A corresponding member,

*With apologies to Spike Lee

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“...when does a person choose to sacrifice his/her significant self-interest in order to try to better the outcomes for others? It is a question that each of us can only answer to ourselves, when we find ourselves facing such a situation, in a moment of truth.”

perhaps reflecting sensitivity to his country’s national ethos, went further when speaking of the CAP’s conflict between loyalty to the individual patient and loyalty to society, and the writer’s emphasis on empathy for the institution’s (or his country’s) limited resources. It fell to William Klykylo, MD, former chair of the ethics committee, to elegantly articulate the underlying ethical reasoning process. To paraphrase: using a utilitarian model, one could theoretically envision soft-pedaling the CAP’s recommendation in favor of instead pursuing the goal of good school-hospital relations, thus in turn preserving resources for other needy children, as might be derived from the ethical justice principle. However, such an approach should be trumped by that action’s breach of fidelity owed to the patient, which would also inevitably render suspect and untrustworthy all future recommendations made to the school system by the CAP. Therefore, in this potential clash of principles, one clearly appears to outweigh the other.

Several commentators offered additional suggestions. Addressing the matter to the hospital’s ethics committee for its review was one; obtaining a second CAP’s opinion, to bolster or contradict the original recommendation, was another. Written formal agreements specifying the degree to which the CAPs are expected to function independently or, by contrast, as extensions of the school system, unrelated to the origins of the funding sources, ought to be established, preferably at the outset of the joint school-hospital operation. As well, parents of children referred for evaluation should be informed beforehand to what extent, if at all, the CAP evaluation might be subject to potential constraints.

One other unanimous response is notable. Not one of the respondents spoke to the CAP’s apparently quite legitimate fear that her/his promotion of the child’s interest could lead to the loss of the CAP’s job. This unanimous non-response led to a second request to the committee members for comments on that specific quandary, and for thoughts about how such a threat might affect a CAP’s ethical reasoning.

Two members commented substantively. One, the above corresponding member, argued for avoiding such predicaments by ensuring that hiring and salary be shared by both parties from the outset, analogous to neutral court appointments for psychiatric evaluations. Arden Dingle, MD, co-chair of the Committee, advised that the physician attempt to clarify, independent of the salary source, what room might exist for the expression of differences of clinical opinion and recommendation with the school system and the clinic administrator. The CAP would then decide if the work setting’s ethical standards are acceptable. If not, the CAP would face three possibilities: leaving the position; trying to remain while advocating for change; or remaining while keeping quiet, in essence endorsing a compromise of patient care. Parenthetically, Dr. Dingle mentioned in passing that the chosen resolution might be made easier by the strong employment demand for CAPs. To the extent that might be a consideration, it is likely that the degree of demand varies with geographic location. In any case, the quandary transcends geographic boundaries and remains a classic one – when does a person choose to sacrifice his/her significant self-interest in order to try to better the outcomes for others? It is a question that each of us can only answer to ourselves, when we find ourselves facing such a situation, in a moment of truth.

CODA: A surprising and unexpected note on which to end this discussion. Upon submission of the final version of this column to AACAP News, the AACAP member who originally sought advice about the case was sent an advance copy. The member’s immediate response commented on the Committee members’ comments, as follows: “Thank you so much for sending me in advance a copy of what will appear in AACAP News. I will absolutely not distribute it before it appears [as requested], despite an infantile desire to wave it in the face of my director! Actually, though I still disagree with him over my cooperating with the child’s counsel, I’ve come to respect that he has the public health point of view represented in the article by William Klykylo, MD. Despite the unanimous agreement that it is most important to protect the best interests of the child, there are other arguments child psychiatrists have to consider that have to do with the overall resources our communities have to offer. At some point we probably have to enter the political process to make changes at that level.”

Dr. Sondheimer is past chair and current member of the AACAP Ethics Committee. He practices in both New York City and New Jersey. He may be reached at adriansondheimer@aol.com. AACAP members who wish to submit ethics questions are invited to contact Dr. Sondheimer at this address.

*This column reflects the professional opinion of the writer and the AACAP Ethics Committee. It is meant to be educational and should not be considered clinical advice or standard of care. Each clinical, research and administrative situation is unique; and each state has different rules and regulations governing medical practice.

Have a question about child and adolescent psychiatry ethics, send an email to AskEthics@aacap.org.
The South African Association for Child and Adolescent Psychiatry and Allied Professions (SAACAPAP) is proud to host the first IACAPAP World Congress to be held on the African continent.

Don’t miss the opportunity of listening to the six outstanding plenary speakers we have lined up!

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In 2014, National Children’s Mental Health Awareness Day is May 8.

The launch event will focus on the unique needs of young adults, ages 16–25, with mental health challenges and the value of peer support in helping young adults build resilience in the four life domains of housing, education, employment and health care access.

Awareness Day seeks to raise awareness about the importance of children’s mental health and that positive mental health is essential to a child’s healthy development from birth.

Communities around the country participate by holding their own Awareness Day events, focusing either on the national theme, or adapting the theme to the populations they serve.

For more information visit:  
http://samhsa.gov/children/national.asp
MARCH/APRIL 2014

MEDIA COMMITTEE

Autism and Me

Manuel D. Reich, DO

In 2011, the Theatre Development Fund, a non-profit that subsidizes musicals and dramatic plays, launched the Autism Theatre Initiative in order to promote theatre to autism spectrum individuals. In October of 2011, The Lion King opened as the first effort of this initiative and it was a success. The third performance of this production opened in Pittsburgh, under the auspices of the Pittsburgh Cultural Trust on September 21, 2013. I attended the sold out matinee which was presented at the Benedum Center for the Performing Arts. This 1928-movie palace, which seats 2,880, was renovated in 1987 for stage and dance productions. The ornate hall with red velvet seats, black marble stairs, and gilded woodwork houses a 4,700-pound crystal chandelier which crowns the auditorium.

Changing the theatre’s physical space was one of many transformations I observed in the mission to make this production autism-friendly. Other changes included keeping all of the house, lobby, staircase, and lounge lights dimmed at all times. Thus, the theatre was never dark nor was it ever bright. The vast, tiered lobby was divided into smaller rooms. These rooms comprised time-out spaces and play spaces for children that needed to leave the auditorium. The performance took place in the glow of the semi-light auditorium with the sound, singing, and stage lights noticeably muted. The actors talked, rather than sang, and there was no projection of voice. Often, members of the audience made noise, sometimes mimicking the animal sounds of the stage, sometimes making sounds of their own. Some caregivers struggled with the children that often could not remain seated or still, and people frequently walked in and out of the hall. Other participants simply walked up and down the aisles, stairs cases, and played on the bannisters. It was a comfort that in this place at this time everyone was autistic or a caregiver of an autistic individual—there was no criticism, no judgment, no harsh or quizzical looks, and no patronizing comments from bystanders. When a water bottle flew across the lobby by one child, another mother simply retrieved it and moved on.

The production had 100 volunteers outfitted in oversized Lion King T-shirts. They provided directions, pamphlets, advice, and direct physical assistance, as well as hearing and visual aides. As the musical proceeded, I became entirely immersed in the world of the autistic individual: the muted sounds, the lighting, and the needs of the children changed the reality in that theatre for the duration of the play. I felt disoriented, in a foreign, and at times, hostile environment. I developed empathy and understanding for the autistic individual that clinical work had never provided. I was expected to tolerate an environment that did not meet my needs, without any possible escape. The auditorium, the lobbies, the stairs, and even the bathroom provided no respite. I only had to live in this environment for two hours. How sad that the autistic individual has to live in the hostile environment of my world every day.

Dr. Reich completed psychiatric training at S.U.N.Y. Downstate and New York University Medical Center. He is a past president of the Pittsburgh Psychiatric Society, a faculty member at the University of Pittsburgh, associate medical director at Value Behavioral Health of PA and medical director of PERSONA, P.C.
Adolescent Boys and Girls Differ in Cannabis Use

While child and adolescent psychiatrists inevitably have different perspectives concerning ongoing public policy debates about marijuana, any such public referendum should be informed by quality data. However, for as much as we do know about the effects of marijuana on development, some fundamental questions, such as how differences between adolescent boys and girls, have not been explored all that well.

Researchers from Yale’s Division of Substance Abuse analyzed data from a statewide survey of 4,523 Connecticut high school students to examine demographic, psychosocial, and risk behavior correlates with smoking marijuana. Findings included:

- Lifetime cannabis use: 40.4%
- Cannabis use in the past 30 days: 24.5%
- Faster transition from initial use to regular use in girls
- Extracurricular activities were generally protective, but boys with extracurricular activities were more likely than girls to smoke cannabis
- Girls who have jobs were more likely to smoke cannabis than boys with jobs
- Boys who smoked cigarettes were more likely to smoke cannabis than girls who smoked cigarettes
- African-American males and white females were more likely to have ever used cannabis

Overall, the study found that adolescent male and female marijuana use is more similar than it is different, with some important differences highlighted above. Such differences can be considered when stratifying individual patients regarding risk or when developing population-level interventions for adolescent marijuana users.


Exposure Therapy Beats Supportive Counseling for PTSD

Although so many children seen by child and adolescent psychiatrists have been exposed to physical or sexual abuse, the limited availability of evidence-based treatments remains a major roadblock to treating these children. Untrained therapists fear worsening symptoms by bringing up memories of past traumas. Trauma-focused cognitive behavioral therapy teaches coping skills before exposure therapy, but finding TF-CBT providers can be a challenge. Prolonged exposure therapy has been shown to be an effective treatment for adults with PTSD.

A recent study from Edna Foa’s group at the University of Pennsylvania randomized 61 adolescent girls with PTSD seeking treatment at a rape crisis center in Philadelphia to receive either supportive counseling or prolonged exposure therapy over fourteen sessions. Interestingly, the therapists were naïve to prolonged exposure therapy and typically provided supportive counseling.

Those receiving exposure therapy had greater improvements on the PTSD symptom severity scale, no longer meeting for PTSD diagnosis, self-reported severity, depression, and global functioning. These differences largely persisted on follow-up a year later.

In addition to the superiority of prolonged exposure over supportive counseling, the study also demonstrates that community mental health clinicians can be trained in prolonged exposure therapy and to deliver it with fidelity, a practicality not often addressed in studies of psychotherapies.


Adolescents Don’t Hear Enough about Sex from Their Physicians

In many states, adolescents do not receive medically accurate information about sexual health at school, and a recent study suggests that physicians (pediatricians, at least) are not doing much to fill in the gap. Researchers, mostly from Duke University, listened to audio-recorded conversations of 253 adolescents seeing 49 physicians at 11 clinics in the Raleigh-Durham area to determine how much time was spent in the visit discussing sexuality issues. The study found that:

- 65% of the visits had some sexual content
- The average time of sexuality talk was 36 seconds
- Visits with female patients (2.5x), older patients (1.4x),

In each issue of AACAP News, we include brief commentary and a link to newsworthy items that the membership might have missed or that merit repeating. If you have suggestions for this column, please send them to me at stuart.goldman@childrens.harvard.edu.
African-American patients (1.6x), and conversations that were explicitly confidential (4.3x) were most likely to have sexual content.

Asian physicians were much less likely to talk about sex.

While this study takes place in a particular context, which may or may not be generalizable, in a state with policies hostile to sexual education, the overall trends identified here do not seem so far-fetched. Child and adolescent psychiatrists may be able to fill some of this gap by expanding the topics they are prepared to discuss with their adolescent patients.

archpedi.jamanetwork.com/article.aspx?articleid=1791584

No Clear Association Found Between SSRIs in Pregnancy and ASD

Various smaller studies have suggested that there may be a link between mothers treating their depression and anxiety with SSRIs and later development of autism in their offspring. Such research can have a chilling effect on parents who fear nothing more than doing something to harm their children. Such a question may be best addressed using a very large data set.

Fortunately, such data sets exist in Scandinavia. Danish researchers conducted a 10-year cohort study of 626,875 single live births and were able to link these births to use of SSRIs before and during pregnancy. 3,892 cases of autism spectrum disorder (ASD) were identified, 52 of which were exposed to SSRIs during pregnancy. After adjusting for potential confounders, the researchers estimated that there was no statistically significant difference in rates of ASD between pregnancies with or without exposure to SSRIs. Interestingly, there was an association amongst women who received SSRIs before pregnancy, but not during pregnancy, a finding open to various interpretations, though unlikely implicating SSRIs directly with later ASD.

Even findings from large data sets must be interpreted with caution given the editorial decisions and statistical methods required to analyze such a complicated data set, and even in this study the confidence intervals describing possible risk of ASD with prenatal SSRRI exposure were relatively wide. However, if such an association does exist between SSRI use during pregnancy and risk for later ASD, its magnitude appears to be elusively small, and such knowledge should better inform pregnant women who suffer from depression and anxiety.


Amygdala Size, Connectivity Predictive of Anxiety Symptoms in Young Children

Child and adolescent psychiatrists have remained frustrated with the lack of clinical applicability of imaging techniques. While many studies have shown differences between populations of children with different diagnoses or problems, few have shown much predictive value for an individual patient. As the questions and methods utilized by researchers continue to improve, the reality of useful information for clinicians using structural or functional imaging may be getting closer.

Stanford researchers combined structural and functional MRI techniques to investigate the effect of anxiety-provoking daily life experiences on the brains of 76 young children aged 7-9 years. While a full discussion of their methods far exceeds a quick read, the researchers report that they could reliably detect individual differences in anxiety by measuring the size of the left basolateral amygdala and the activity of various amygdala-linked circuits involved with attention, emotion perception, and regulation, even at a young age before the onset of an anxiety disorder. While further study will be necessary to clarify how such information could specifically be used in a clinical setting, psychiatry appears to be moving much nearer to the clinically valuable biomarkers that have remained elusive for many years.


www.biologicalpsychiatryjournal.com/article/S0006-3223(13)00912-8/

When to Change Horses?

Treatment decisions about when to change agents in the treatment of the major psychiatric disorders are complex. Balancing adequate dose/adequate time considerations with the need for symptomatic and functional relief have pulled clinicians into divergent positions, i.e. “How long do I stick with an agent before moving on?” Controlled studies have been much needed, and Correll et al, in the July JAACAP, addresses this question at least for aripiprazole and schizophrenia. They enrolled approximately three hundred 13-17 year olds with schizophrenia and a PANSS score of at least 70 into their 6 week prospective study. Subjects were divided into 10mg, 30mg (treatment), and placebo groups. PANSS were repeated each week for 6 weeks. Each group had about 100 participants. They identified early responders at 2 weeks (ER2) and 3 weeks (ER3), as well as ultimate responders (UR), and each of these were further broken down in to 20%, 30%, and 40% reductions in PANSS. Generally speaking, 20% was the cutoff for minimal improvement and 40% for moderate improvement. For example responders, could be labeled ER2/20 or ER2/40, etc. They also labeled early non-responders at 2 weeks (ENR2), 3 weeks (ENR3), and at 6 weeks (UNR).

The study found that in both the 10 and 30 mg groups, the vast majority of the improvement that was going to be seen by week 6 occurred in the first three weeks of treatment. Looking continued on page 82
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more closely at odds ratios, ER2 patients were 10.8 times more likely to respond than ENR2, and ER3 were over thirty times more likely to respond than ENR3 patients at the UR40% level. In the author’s words, “early total symptom improvement at weeks 2 and 3 was associated with significantly greater improvements at study endpoint in positive and negative symptoms, global functioning scores, and quality-of-life measurements.” When sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), and overall accuracy were examined, the presence or absence of significant reduction in PANSS by week 3 reliably identified patients who were not likely to benefit from continued medication trial. Of note, there were no statistically significant differences in the 10 and 30 mg groups.

The authors also noted that given the aripiprazole’s long half-life and their gradual titration of the medications, earlier predictive changes might be possible for other agents. The take away message is that for adolescents with schizophrenia with confirmed medication adherence to aripiprazole, the three week cutoff for identifiable response should be used. In this population, with this medication, persistence after three weeks of non-response does not add real value and delays treatment that may be more effective. While this is only one study with one agent, it represents and clear and important starting point.


www.jaacap.com/article/S0890-8567(13)00301-8/

Black Boxes, Suicide Risk, and Antidepressant Type

About a decade ago, the FDA put a black box warning on antidepressant usage for adolescents and young adults because of a putative increased risk of suicide/suicidal behavior. This warning was temporally associated with (most believe caused) a prompt decrease in prescription rates and an actual increase in completed suicides. Multiple studies and papers followed, trying to more clearly parse out the actual risk/benefit components. While it is quite clear that for most practitioners the judicious, evidence-based, approved usage of agents is indicated, questions about whether risk is variably associated with differing agents remain. This is particularly true when practitioners have to go beyond the two FDA approved agents (fluoxetine and escitalopram) for non-response and go on to off-label agents. In other words, do some agents entail more risk than others?

In Cooper et al.’s review of almost 37,000 new (usage in past 365 days) antidepressant users aged 8- to 18-years, they analyzed “medically treated” suicide attempts, acts, or completions. The rates for all identified suicidal acts for fluoxetine, sertraline, paroxetine, citalopram, escitalopram, and venlafaxine were each between 2.4 to 2.9/100 patients, with no statistical difference. For youths who were treated with multiple SSRIs or SNRIs, the rate more than doubled (probably an indicator of severity). There appeared to be no difference among the agents whatsoever, which helps inform our decisions regarding switches from one antidepressant to another.


pediatrics.aappublications.org/content/early/.../peds.2013-0923d.abstract

More Potentially Modifiable Risk Factors: Maternal Smoking and Bipolar Disorder

Also to be filed in the “correlation does not mean causation, except sometimes it does” folder is a study from the October green journal looking at some of the risks of smoking during pregnancy on offspring. Previous research has found that maternal smoking is associated with any number of externalizing behaviors, ADHD, and other cognitive problems. Researchers identified nearly 80 cases of offspring with bipolar disorder from the Child Health and Development Study. Comparison subjects were matched on date of birth, sex, and several other important factors. After adjusting for a multitude of other factors, the offspring of parents who smoked had a two-fold increase in risk for bipolar disorder. Such retrospective studies are quite imperfect, and even the best statistical models that try to control for all of the variables that may obscure an association generally fail to do so. However, the appropriate clinical question does not necessarily require a precise answer to a research question to inform our practice and counseling. What is the risk of quitting smoking while pregnant? Well, it is not an easy thing to do, but other than some frustration and potential miserable-but-not-dangerous withdrawal symptoms, not much. What are the upsides? We do not always know. For the offspring, there seems to be plenty, and one of those may be decreasing a future risk of bipolar disorder. There are plenty of reasons to hope for a definite answer in the future, but in the meantime, we do best for our families by sharing with them our best knowledge, even if it is not perfect.


ajp.psychiatryonline.org/article. aspx?articleid=1746572
Join other AACAP members, and family and youth advocates May 8-9, 2014, to promote child and adolescent psychiatry and children’s mental health issues on Capitol Hill.

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

For more information visit
www.aacap.org/AACAP/Advocacy/AACAP_Advocacy_Day/Home.aspx
or contact Zachary Kahan, Legislative Coordinator, at zkahan@aacap.org or 202-966-7300 ext. 128.
PROJECTIVE RECOGNITION

misidentifying strangers
as people you know

often occurs while travelling

like, the dude three chairs down the beach
could be that kid from high school
what’s his name? Dennis?
or the girl at the coffee cart
could be your cousin Amy

except she isn’t Amy
and he isn’t Dennis

and if you’re not otherwise busy
you can spend productive time
remembering Amy or Dennis
and why you might want to see them

projective recognition

Individuals interested in submitting poetry should e-mail Poetry Coordinator Charles Joy, MD, at crjoy1@gmail.com.
Update on the *Back to Project Future* Report: The Plans Unfold

**Martin J. Drell, MD**  
AACAP Past President

During my tenure as AACAP President (2011-2013), *Back to Project Future* (BPF) was one of my Presidential Initiatives. In the *AACAP News* article “Onward into the Coming Decade!” that appeared in the September/October 2013 issue, James MacIntyre, II, MD, chair of the BPF Steering Committee, announced that its final report, “Back to Project Future: Plan for the Coming Decade,” had been submitted to me. The report concluded 18 months of hard work by many AACAP members and staff comprised of honorary editors (Richard Cohen, MD, and Norbert Enzer, MD); the steering committee (Drs. Alan Axelson, Michael Houston, Paramjit Joshi, Sheryl Kataoka, Debra Koss, James MacIntyre, Richard Martini, David Pruitt, Neal Ryan, and Heather Walter); and Executive Directors Virginia Anthony and Heidi Fordi, CAE, consecutively); three BPF subgroups (Services/Clinical Practice, Training and Workforce, and Research), distinguished consultants, input from other organizations, and an ongoing dialogue with many of our members. I wholeheartedly accepted the plan, which represents a valuable gift to AACAP. It includes:

- An executive summary.
- An overview of major issues and themes in child and adolescent psychiatry that are anticipated in the next decade.
- A plan for dealing with those issues.
- A special topics section that focuses on 6 key areas.
- Suggestions as to the next steps to take.

A multipronged strategy was created to educate the membership as to its intent and content. The strategy involved:

1) Putting the document on the AACAP website ([www.aacap.org](http://www.aacap.org))
2) *AACAP News* articles
3) Numerous discussions with the Executive Committee
4) Numerous presentations at the 2013 Annual Meeting in Orlando, Florida:
   - Comments by the President at the Opening BPF Town Hall
   - Presentations to the Council, the Assembly, and to committee chairs
   - Presidential interview with James MacIntyre, II, MD

The presentation to the Council on Wednesday, October 23, 2013, culminated with a motion that the BPF report be accepted. It passed unanimously and was followed by another motion charging Paramjit Joshi, MD, incoming AACAP president (2013-2015), to create an infrastructure to implement the report’s suggestions. This too passed unanimously.

Acting on this, Dr. Joshi created a task force that will analyze the document, its goals, recommendations, and action steps, and suggest priorities for implementing it. The task force members include: Neal Ryan, MD, Deborah Koss, MD, and Stephen Cozza, MD.

I look forward to the Implementation Task Force’s work, which will be important in framing how AACAP will handle the opportunities and challenges in the next decade as healthcare reform and other events unfold. Clearly, child and adolescent psychiatrists will respond to these opportunities and challenges. I hope that the comprehensive and thoughtful BPF report will allow for proactive responses that, despite the uncertainties and anxieties any major change engenders, will propel our field forward. As always, the goal is to have AACAP and its members better fulfill our mission of helping children and their caregivers to live better lives.

As I end, I am reminded of a quote from William Faulkner’s speech upon winning the 1950 Nobel Prize. The quote was greatly influenced by his very real anxieties over the Cold War and that era’s threat of nuclear annihilation. It reads, “I believe that man will not merely endure, he will prevail.” I have similar sentiments and feelings for the wonderful field of child and adolescent psychiatry.

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Dr. Drell is past president of AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. Dr. Drell may be reached at MDrell@lsuhsc.edu.
CPT Coding 101
(for introduction and reference)

For those new to practice and/or coding for the first time, here’s a bit of an alphabet soup primer.

CPT is a system set by the American Medical Association (AMA) that uses 5-digit codes, and occasionally 2-digit modifiers, to describe all services and procedures provided by individual health care professionals. CPT codes are listed in the CPT manual, revised yearly by the AMA.

E/M codes describe patient visits to medical professionals, including physicians, physician assistants, and advanced practice nurses. Visits may occur in a variety of settings, including office, hospital, partial hospital, and home. E/M codes describe “services,” including initial evaluation, follow-up, and acute care. All other codes describe “procedures,” which range from appendectomy to psychotherapy, and may be provided by any health care professional qualified to perform them.

The RUC recommends RVUs for each code to CMS, which after public comment and review, publishes the final RVUs in November. Actual Medicare reimbursement is determined by a rather complicated process involving annually-adjusted national conversion and local geographic adjustment factors. Private payers and Medicaid programs are not bound by each code’s RVU but may consider it in their own calculation of reimbursement rates.

See the AACAP website www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/CPT_and_Reimbursement.aspx?hkey=e53bd2fa-d1f9-4db5-bbfa-17f48bec4e35 for extensive coding educational materials, including details of criteria for E/M codes. Contact Jennifer Medicus at jmedicus@aacap.org or 202.587.9670 with questions.

Jason Chang, MD,
and the AACAP CPT Coding Subcommittee

AMA: American Medical Association
E/M: Evaluation and management
RUC: AMA Relative-value Update Committee
CMS: The Centers for Medicare and Medicaid Services
RVU: Relative value unit
Interactive Complexity

Interactive complexity may be reported with one of the following psychiatric “primary procedures”:

- Psychiatric diagnostic evaluation – 90791, 90792
- Psychotherapy – 90832, 90834, 90837
- Psychotherapy add-on codes – 90833, 90836, 90838 (when reported with E/M)
- Group psychotherapy – 90853

When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work intensity of the psychotherapy service and does not change the time for the psychotherapy service.

Interactive complexity may NOT be reported with:

- Psychotherapy for crisis – 90839, 90840
- Family psychotherapy – 90846, 90847, 90849
- E/M alone, i.e., E/M service not reported in conjunction with a psychotherapy add-on service

Report 90785 when at least one of the following specific communication factors is present during the visit:

1. The need to manage maladaptive communication (e.g., related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.

2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.

3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

4. Use of play equipment or physical devices to overcome barriers to diagnostic or therapeutic interaction with a patient who has not developed, or has lost, expressive or receptive language skills to use or understand typical language.

The interactive complexity add-on code, 90785, may be used to more accurately describe the work of child and adolescent psychiatrists and other mental health professionals, and may increase reimbursement for certain services.

M anagement of various patient and other participant interactions during visits has always been a significant aspect of the work in the mental health treatment of children and adolescents. Generally, the same codes are used as for treatment of adults, despite the frequent need for greater effort and skill. Interactive complexity helps to narrow the disparity. New in 2013 and reported with CPT add-on code 90785, interactive complexity is more important this year after vaulting from an RVU of 0.14 in 2013 to an RVU of 0.40 in 2014.

Benjamin Shain, MD, PhD,
and the AACAP CPT Coding Subcommittee

A gift in your will takes a simple designation and costs you nothing during your lifetime.

It is a “tomorrow” donation made today.

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Visit www.aacap.org/1953_Society
According to AACAP’s 60th Annual Meeting evaluations, the highest rated sessions in each presentation category were:

**Clinical Case Conference 9:** A Quantum of Solace: Managing the Peer Review  
Chair: Cheryl S. Al-Mateen, MD

**Clinical Consultation Breakfast 3:** Master Clinician Efrain Bleiberg, MD: Attachment Theory, Personality Disorders, and the Application of Mentalization  
Chair: Efrain Bleiberg, MD

**Clinical Perspectives 40:** The Role of Mental Health in Promoting Safe and Supportive Schools  
Chair: Sharon H. Stephan, PhD

**Honors Presentation 7:** Pediatric Trichotillomania  
Chair: Michael H. Bloch, MD, MS

**Institute 8:** Communication and Language Development Implications for Clinical Practice  
Chairs: Susan E. Swedo, MD, and Siham Muntasser, MD

**Media Theatre 11:** Towards Attaining Immortality: An Adolescent’s Reflections on His Own Chronic Illness and Death  
Chair: David Buxton, MD

**Member Services Forum 6:** Ethical and Practical Considerations of Working with the Media  
Chairs: Carlene MacMillan, MD, and Stephanie Hartselle, MD

**Special Interest Study Group 10:** Problem-Based Learning in Child and Adolescent Psychiatry  
Chair: Norbert Skokauskas, MD, PhD

**Symposium 13:** Developmental Pathways to Addiction: Origins of Risk Connected to Interventions within a Patient-Centered Framework  
Chair: Michelle S. Horner, DO

**Workshop 6:** Voicing My CHOICES™: A Workshop on Addressing Advance Care Planning for Adolescents and Young Adults  
Chair: Maryland Pao, MD

Please note that these rankings are determined by average overall ratings on session evaluations. Enrollment numbers did not influence ranking.

**Congratulations to all the presenters!**

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We would like to acknowledge the first ten sessions to sell-out at AACAP’s 60th Annual Meeting. In chronological order based on sell-out date, they are:

**Clinical Consultation Breakfast 5:** Master Clinician Tanya K. Murphy, MD: Searching for Answers and Evidence-Based Treatments: Obsessive Compulsive Disorder, Tic Disorders, Phobias, PANDAS/PANS, and More  
Chair: Tanya K. Murphy, MD

**Clinical Consultation Breakfast 3:** Master Clinician Efrain Bleiberg, MD: Attachment Theory, Personality Disorders, and the Application of Mentalization  
Chair: Efrain Bleiberg, MD

**Clinical Consultation Breakfast 4:** Master Clinician James J. McGough, MD, MS: ADHD: To Medicate or Not to Medicate—The Controversies of Treatment  
Chair: James J. McGough, MD, MS

**Workshop 16:** How to Use Medications for Youth with Substance Use Disorders: Real World Questions and Answers  
Chair: Geetha A. Subramaniam, MD

**Workshop 20:** Assessment and Treatment of Challenging Behavior in Neurodevelopmental Disorders: The Maudsley Model  
Chair: Emily Simonoff, MD

**Clinical Consultation Breakfast 9:** Guide to Psychotic Disorders Due to General Medical Conditions in Children and Adolescents  
Chair: Susan Beckwitt Turkel, MD

**Special Interest Study Group 4:** CPT Coding Development and Implementation for Child and Adolescent Psychiatrists  
Chair: Benjamin Shain, MD, PhD

**Special Interest Study Group 12:** Tourette’s Disorder and Related Disorders  
Chair: Robert A. King, MD

**Special Interest Study Group 2:** College Student Mental Health  
Chair: Adrian Sondheimer, MD

**Workshop 35:** National Institutes of Health Research Priorities and Competitive Grant Writing for Success  
Chair: Cheryl Boyce, PhD

Thank you to all of the Annual Meeting speakers for your contributions to AACAP!
Did you miss the Annual Meeting in Orlando? Are you looking to learn something new? 
AACAP has just what you need!

- Hear top-rated speakers on hot topics in the field
- Review best practices
- Find answers to issues in clinical practice
- Catch up on sessions you missed

Session recordings from the 60th Annual Meeting (now including PowerPoint slides) are available in a variety of different packages. Purchase individual sessions, the full conference set, or take advantage of our ADHD, Mood Disorder, or Institute bundles offering Annual Meeting highlights at a reduced cost. Also, be sure to check out our two FREE symposia on DSM-5.

Visit AACAP’s Learning on Demand at http://aacap.sclivelearningcenter.com for more information.

No CME credit is available with session recordings. Session availability subject to speaker permission.

Attention Life Members!

Stay involved.
Stay connected to all Life Members activities, programs, and photos by reading the Life Members eNewsletter distributed quarterly via e-mail. Did you receive the latest Life Member eNewsletter in March?

Impact.
In 2013, we approved 29 new grants, 15 residents and 14 medical students. Which means that, since 2010, the Life Members Fund has made an investment in 37 residents and 31 medical students. This has been achieved through its two grant awards, Education Outreach for Child and Adolescent Psychiatry Residents and Mentorship Grants for Medical Students. 68 lives you impacted, who are and (we hope) will become the next generation of child and adolescent psychiatrists.

Donate.
This achievement is remarkable. What makes this even more remarkable is that 23% of Life Members have made donations since 2010 to provide the funding for these 68 grant awards. What if we could inspire the other 77% of our Life Member colleagues to donate, no telling how many grant awards we can make.

Are you up for a challenge? Let’s think 37 new grants for 2014! To fund one new grantee, it’s an investment of $1,350. We can raise this any number of ways. One Life Member can donate $1,350. Some of us can do this, many cannot. Or, 7 Life Members can each donate $16/month. All donation amounts will add up to get us to 37.

To donate, visit www.aacap.org/donate.

Membership:
Do you think you are a Life Member? AACAP Members qualify as Life Members when your age plus your years of AACAP membership equals 98.
Don’t miss this opportunity to save money on your Annual Meeting registration!

AACAP members who refer a new Annual Meeting exhibitor receive a $100 discount on their 61st Annual Meeting registration.

All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP’s 61st Annual Meeting.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals or advertise in several Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and many more.

An Exhibitor Prospectus with more details on these opportunities, as well as forms to sign-up, will be available starting in May at www.aacap.org/AnnualMeeting/2014.

Questions? exhibits@aacap.org or 202.966.7300 ext: 2006

Show your support for AACAP and SAVE TODAY!

New Research Poster Call for Papers

AACAP’s 61st Annual Meeting takes place October 20-25, 2014, at the Manchester Grand Hyatt and Marriott Marquis and Marina in San Diego, California. Abstract proposals are prerequisites for acceptance of any presentation. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, administration, etc. AACAP encourages submissions on neurodevelopmental interventions (helping children grow healthy brains), translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and violence prevention.

Verbal presentation submissions were due February 18, 2014, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by Monday, June 16, 2014, and the online submission site will open in early April. All Call for Papers applications must be submitted online at www.aacap.org. If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
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Refer a Colleague!

Do you have a colleague who would benefit from being a member of the Academy? Contact the Member Services Department to have a prospective member packet sent on your behalf.

Contact AACAP Member Services at 202.966.7300, ext. 2004 or by e-mailing membership@aacap.org with your colleague’s contact information.

AACAP Election Policy

(approved by the Executive Committee March 23, 2001)

The ballot to elect two Councilors-at-Large and two Nominating Committee members is mailed in May 2014. The election ends May 31, 2014. Ballots will be held for three months after the election, during which time anyone who wishes to contest the election can do so. After three months the ballots will be destroyed.

CAMPAIGNING IS PROHIBITED IN AACAP ELECTIONS.
Welcome New AACAP Members

Nana Achampong, Mason, MI
Digisha Agarwal, MD, Springfield, IL
Aaron Alexander-Bloch, Venice, CA
Carla Alvarado, MD, El Paso, TX
Benjamin Anderson, MD, White Plains, NY
Rita Aouad, MD, Columbus, OH
Omar Bashayan, MD, New York, NY
Matthew Baum, Boston, MA
Kathleen Bock, Chicago, IL
Naveena Boindala, MD, Spencer, OK
Elizabeth Calvin, MD, Aurora, CO
Daniel Cardona, MD, Cold Spring, KY
Mamatha Challa, Chicago, IL
Tiffan Chambers, Providence, RI
Anne Cohen, MD, Belfast, ME
Mary Daley, MD, Lunenburg, MA
Srinivas Dansaram, MD, Omaha, NE
Edwin De Leon, MD, Fullerton, CA
Christina Dean, Durham, NC
Matthew Dobbertin, MD, Omaha, NE
Sarah Domb, MD, Los Angeles, CA
Amanda Dorn, MD, Cary, NC
Sahar Douek, MD, Sherman Oaks, CA
Kimberly Downing, Sound Beach, NY
Jessie Duncan, Chicagao, IL
Kathleen Dunlap, MD, Durham, NC
Eugene (Gene) Fletcher, DO, Irving, TX
Ali-Reza Force, New Canaan, CT
Jessica Frank, Loves Park, IL
Ruben Gagarin, MD, Scarborough, Ontario, Canada
Jamie Gainor-DiPietro, MD, East Providence, RI
Rishi Gautam, MD, Jersey City, NJ
Larissa Grace, MD, Bakersfield, CA
Elisha Greggo, MD, Columbia, SC
Chrisalbeth Guillermo, Henderson, NV
Ahmed Hefuna, MD, Washington, DC
Elizabeth Helton, MD, Pittsburgh, PA
Alexis Hinds, MD, MBA, Los Angeles, CA
William Holmes, MD, Austin, TX
Yaejee Hong, Cincinnati, OH
Joseph Horvath, Boardman, OH
Soonjo Hwang, MD, Bethesda, MD
Anand Joshi, MD, Sioux Falls, SD
Lianna Karp, Providence, RI
Narpinder Kaur, MD, Omaha, NE
Matthew Krasucki, MD, Grafton, WI
Tricia Kwiatkowski, North Bethesda, MD
Michelle Latting, Chicago, IL
Caitlin Lawerence, Plainville, MA
Chuan Mei Lee, MD, San Francisco, CA
Ruby Lekwauw, MD, New Haven, CT
Maria Manouselis, DO, Hartsdale, NY
Mazen Maria, MD, Valhalla, NY
Sarah Martin, MD, El Paso, TX
Tamara Martinez, Denver, CO
Maria McCarthy, MD, Philadelphia, PA
Corey Meador, Philadelphia, PA
Francisco Mendoza, Sacramento, CA
Erlinda Mercado, MD, Lapeer, MI
Richard Mickelsen, MD, Alpine, UT
Keith Miller, Rochester, MN
Robin Mogul, MD, Cleveland, OH
Shane Moiso, MD, Milwaukee, WI
Veronica Murphy, MD, East Elmhursts, NY
Jeffry Mutuc, Chicago, IL
Tarika Nagi, MD, Brooklyn, NY
Kate Nyquist, MD, Newton, MA
Francelle Okongwu, MD, North Brunswick, NJ
Nnenna Okoye, Chicago, IL
Peter Oliver, MD, Durham, NC
Mitch Otu, Los Angeles, CA
Juan David Palacio, MD, Medellin, Antioquia, Colombia
Kimberly Papa, MD, Richmond, VA
Michael Papirny, MD, Calgary, Alberta, Canada
Simu Paul, MD, Princeton North, NJ
Zoya Popivker, DO, Glen Oaks, NY
Muhammad Puri, MD, Paramus, NJ
Ilene Rabinowitz, MD, Chappaqua, NY
Erik Roberts, Jamaica Plain, MA
Catherine Rogers, MD, Chapel Hill, NC
Tracey Roiff, MD, New York, NY
Kacie Rounds, Sacramento, CA
Madlena Rush, DO, Winston Salem, NC
Douglas Russell, MD, Los Angeles, CA
Joshua Russell, MD, Buffalo, NY
Gregory Sayer, MD, Los Angeles, CA
Debbie Schachter, MDCM, Toronto, ON, Canada
Marissa Schiel, MD, Highlands Ranch, CO
Shervin Shadianloo, MD, New York, NY
Khushbu Shah, Schaumburg, IL
Rie Shary, Shreveport, LA
Frances Shin, MD, Lebanon, NH
Hannah Simon, Piscataway, NJ
Andrew Skoirchet, Champaign, IL
Tina Thakrar, MD, Gordonsville, VA
Corey Thompson, Chicago, IL
Sara VanBronkhorst Schafersma, Wyoming, MI
Elizabeth Wagner, New Orleans, LA
Anne Wagner, Rochester, MI
Anna Wehry, Edgewood, KY
Trevor Wells, MD, Long Beach, CA
Semone West, MD, Chicago, IL
Emily Williams, MD, Columbia, SC
Margaret Woodbury, Bethesda, MD
Annie Yeh, New Orleans, LA
Distinguished Member Awards

Nomination Deadline: April 30, 2014

AACAP is pleased to offer the following award opportunities to our many outstanding members. For details about all awards, eligibility requirements, and for access to applications and nomination information, please visit the AACAP Awards Webpage at: http://www.aacap.org/AACAP/Awards/Distinguished_Member_Awards/Home.aspx

All Distinguished Member and Service Awards are conferred through a nomination process. Distinguished Member and Service Award recipients will be recognized at the Distinguished Members Awards Luncheon and will give an Honors Presentation regarding their work at AACAP’s 61st Annual Meeting, October 20-25, 2014, at the Manchester Grand Hyatt and Marriott Marquis and Marina in San Diego, CA.

The AACAP Irving Philips Award for Prevention recognizes a child and adolescent psychiatrist AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents. The award offers $2,500 to the award recipient and a $2,000 donation to a prevention program or center of the recipient’s choice.

The AACAP George Tarjan Award for Contributions in Developmental Disabilities recognizes a child and adolescent psychiatrist AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with developmental disabilities. The award recipient will receive an honorarium of $1,000.

The AACAP Sidney Berman Award for the School-Based Study and Intervention for Learning Disorders and Mental Illness recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness. The award recipient will receive an honorarium of $4,500.

The AACAP Simon Wile Leadership in Consultation Award, supported by the Child Psychiatry Service at Massachusetts General Hospital acknowledges outstanding leadership and continuous contributions in the field of liaison child and adolescent psychiatry. The $1,000 award is named after Simon Wile, MD, a renowned pediatrician and a life-long supporter of child and adolescent psychiatry.

The AACAP Norbert and Charlotte Rieger Service Program Award for Excellence recognizes an innovative program that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serves as a model program to the community. The awardee will receive $3,000 and his or her service program will also receive $1,500.

The AACAP Cancro Academic Leadership Award
This award recognizes a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of a Department of Pediatrics or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry. Named in honor of Robert Cancro, MD, Chairman at New York University, this award offers a $2,000 honorarium to the awardee.

The AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award recognizes the best published (within 3 years) or unpublished paper, written by an AACAP member, that addresses the use of psychodynamic psychotherapy in clinical practice and fosters development, teaching, and practice of psychodynamic psychotherapy within child and adolescent psychiatry. Authors with papers that express a novel hypothesis, raise questions about existing theory, or integrate new neuroscience and developmental psychotherapy research with psychodynamic principles may be nominated. The award recipient will receive a $4,500 honorarium.

The AACAP Robinson-Cunningham Award is given for the best manuscript written by a child and adolescent psychiatrist. The paper must have been started during residency training (Child or General), and involve children, adolescents, or their families. The paper should be published in a professional, peer-reviewed journal within three to five years of graduation from the training program, and the candidate must be the first author. Each paper will be rated for originality and potential impact. The award recipient will receive a $1,000 honorarium.

AACAP Paper Prizes

The AACAP Jeanne Spurlock Lecture and Award on Diversity and Culture recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in the United States and the world as it pertains to children’s mental health, and who will support the recruitment of child and adolescent psychiatrists from all cultures. The award provides the recipient an honorarium of $2,500.
Award Opportunities for Child and Adolescent Psychiatry Residents and Junior Faculty

AACAP is pleased to offer the following awards for residents and early career psychiatrists! For more information on these awards, see below or visit the AACAP Awards page.

**Junior Investigator Award**

Supported by AACAP’s Research Initiative. The Research Initiative is sponsored by Eli Lilly and Company and Shire Pharmaceuticals.

**APPLICATION DEADLINE: MARCH 14, 2014**

This award offers $30,000 a year for two years for up to two child and adolescent psychiatry junior faculty (assistant professor level or equivalent). The recipient has the opportunity to submit a poster presentation on his or her research for AACAP’s 63rd Annual Meeting in New York, NY, October 25-30, 2016. This award also includes funding support to attend the Annual Meeting for five days.

**AACAP Pilot Research Award for General Psychiatry Residents**

Supported by Lilly USA, LLC and Pfizer, Inc.

**APPLICATION DEADLINE: APRIL 30, 2014**

This award offers $15,000 for up to nine general psychiatry residents who have an interest in beginning a career in child and adolescent mental health research. Recipients have the opportunity to submit a poster presentation on their research for AACAP’s 62nd Annual Meeting in San Antonio, TX, October 27 – November 1, 2015. Each award also includes funding support to attend the Annual Meeting for five days.

**AACAP Pilot Research Award for Attention Disorders and/or Learning Disabilities for CAP Residents and Junior Faculty**

Supported by the Elaine Schlosser Lewis Fund

**APPLICATION DEADLINE: APRIL 30, 2014**

These awards offer $15,000 to up to two child and adolescent psychiatry residents and junior faculty who have an interest in beginning a career in child and adolescent mental health research. Award recipients have the opportunity to submit a poster presentation on their research for AACAP’s 62nd Annual Meeting in San Antonio, TX, October 27 – November 1, 2015. Each award also includes funding support to attend the Annual Meeting for five days.

The distribution of all awards is contingent upon the receipt of adequate funding. AACAP reserves the right to waive liabilities.

For a complete listing of award opportunities or for more information, please visit the AACAP website www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Home.aspx or e-mail research@aacap.org.
“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around—nobody big, I mean—except me. And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff.”

AACAP recognizes and promotes advocacy for children. To better recognize outstanding advocacy efforts, the AACAP established three advocacy awards to:

- Recognize an **individual** that advocates for children (must be an AACAP member)
- Recognize an **AACAP component** that best advocates for children
- Recognize a **regional organization** of child and adolescent psychiatry whose activities best highlight the contributions of regional organizations on behalf of children.

The award title was taken from Dr. John Schowalter’s Presidential Address in which he alluded to J.D. Salinger’s book and Holden Caulfield’s response to what he wanted to be when he grew up.

Nominations should include a brief paragraph describing the nominee’s work. The Assembly Executive Committee serves as the selection body.

Awards will be presented at the Assembly meeting during the AACAP Annual Meeting in October in San Diego. Please forward your nominations to:

Earl Magee
AACAP
3615 Wisconsin Avenue, N.W.
Washington, DC 20016
or e-mail to emagee@aacap.org

The deadline for nominations is June 30, 2014.
POLICY STATEMENTS

AACAP Policy Statement Requirements

Policies should:

1) be a statement regarding an important policy issue,
2) be a well-written statement, as brief as possible,
3) identify the target audience,
4) have the potential of having some specific impact, and
5) include ideas for distribution.

Platitudinous statements supporting “Apple Pie and Motherhood” or condemning the multitude of actions, behaviors, social events, or cultural patterns which may have some negative effect on children and families are not likely to serve the AACAP well and may, ultimately, undermine the credibility of AACAP efforts in other areas.

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

Policy Statement Procedures

Once a final draft policy statement is submitted by an individual author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Committee (PSAC) via the National Office, the Policy Statement Advisory Committee Chair directs that:

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

  OR

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

If the PSAC recommends it, the Executive Committee reviews the statement to decide whether it should be e-mailed to Council or placed on Council’s meeting agenda. If the Executive Committee decides not to advance the statement, the author(s) may be contacted to resolve the issue(s).

If e-mailed, Council members have a two-week discussion period in which to convey concerns and ask questions. After this period, a one-week voting period begins.

If Council approves the statement, the author(s) is notified. The statement is printed in AACAP News and distributed to the recommended sources then placed on the AACAP website.

If Council does not approve the statement, the author(s) may be requested to rewrite and resubmit to the PSAC with an explanation of what changed.

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

Annually, committee chairs are asked to review policy statements online and update if necessary.

*revised 10/2012
APRIL AND MAY’S DONATIONS ARE AS IMPORTANT AS DECEMBER’S!

......IN THE LIFE OF A CHILD.

When you read this, we’ll be three months into 2014, and long past our new year’s resolutions. And, while you made 2013 an amazing year because of your capacity to care, March and April, and all of 2014 is when we must catapult our momentum.

You always rise to great challenges.

Fighting for what we know we must do for children with mental illnesses is a great challenge worth fighting for.

Remember, this year you can tell us if you would like us to invest your donation in Advocacy, Workforce, Research, or International initiatives.

These are just a few examples:

You can donate $57 a month and sponsor a child or parent to attend Advocacy Day.

You can donate $3,500 and sponsor one medical student in a 12-week fellowship. You can donate $2,500 and sponsor a travel scholarship for one international student or resident to attend the Annual Meeting.

Or, you can make a general donation, and we’ll invest it where it’s most needed to achieve greatest impact. Whatever you decide, please donate. Invest in the fight.

Visit www.aacap.org/donate and change her life.

PLEASE DONATE NOW.
Donate Your Birthday!

Will you donate your next birthday?

“What do you mean?”

In 2013, we launched a new online fundraising program, called Peer-to-Peer (P2P) fundraising. New technology makes this incredibly easy to set up and fun to do.

Basically, you create a personalized fundraising page. This page tells “your story.” You e-mail this page to your friends, family, and loved ones. The “ask” for the donation is already in your page.

That’s it.

Why not “give up your birthday” and fundraise for a cause you care about passionately: AACAP! Even better, you can be very specific about what you’re supporting advocacy, research, workforce, and international projects.

Here’s what’s pretty cool about this. Everyone has a birthday. So, you can’t hide. Just kidding. But, we do have more than 8,700 members at AACAP. That’s a lot of birthdays and fundraising opportunities.

In 2014, why not set up a personal birthday fundraising page?

Instead of presents, ask your friends and loved ones to donate to the cause you’re most passionate about: changing the lives of children with mental illness!

Visit Donate.AACAP.org

AACAP Listservs

What is a Listserv?

A listserv is an electronic mailing list of people who have opted to receive specific information. A listserv allows for the distribution of information to many people at one time. For AACAP, listservs provide an easy means for the organization to reach its members or specific groups of members who have selected to receive certain information on AACAP programs, products and events.

AACAP offers the following listservs (whether open to the public, all AACAP members, or limited to specific groups within AACAP):

**Communications & Member Services**

News Clips (open to public) (contact Stephanie Chow at schow@aacap.org)

**Executive**

Assembly@aacap.org (for Assembly) (Earl Magee)

Deaf@aacap.org (for Deaf and Hard of Hearing Committee) (Earl Magee)

**Government Affairs & Clinical Practice**

blackcaucus@aacap.org (members only) (contact Jen Medicus at jmedicus@aacap.org)

latinocaucus@aacap.org (members only) (contact Jen Medicus at jmedicus@aacap.org)

**Research, Training & Education**

Training Directors (for training directors) (Ashley Partner)
Thank You for Supporting AACAP!

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

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FOR YOUR INFORMATION

Share Your Photo Talents With AACAP News

The Editorial Board of AACAP News is soliciting photographs from AACAP members to be published on its front page, inside standing alone, or accompanying relevant articles or stories. The published photographs should—in some artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. All AACAP members are invited to submit up to two photographs every two months for consideration.

A committee of five experienced photographers who are AACAP members—David Corwin, M.D., James Harris, M.D., Fred Seligman, M.D., Ludwig Szymanski, M.D., and Alvin Rosenfeld, M.D.—will select the photos to be used. Photos not selected will be included in the voting for the subsequent two issues, along with all newly submitted photos. Unused photos will be retained by the AACAP to be used if and when a story they might illustrate is to be published. The AACAP News may edit photos to enhance them or make them suitable for publication. If you would like your photo(s) considered, please send a high-resolution version to Dr. Rosenfeld, the AACAP News photo editor, at ARosen45@aol.com. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.

DREAM JOB

PSYCHOTHERAPY SAVVY PSYCHIATRIST

Live and work on the culturally vibrant Zuni Pueblo in New Mexico. Full spectrum care: Freedom to do psychotherapy or meds as you see fit without managed care or productivity; Cross-cultural care; Crisis Evale; Work with Adults and Child; Co-design community mental health. Seasoned colleagues. Excellent Federal Benefits. Market Pay, No Call.

Feel good about your care in a place where your skills are needed and valued.

Zuni Indian Health Services, Contact: Joy McQuery, MD joy.mcquery@ihs.gov
FULL-TIME POSITION  
CHILD & ADOLESCENT PSYCHIATRIST  
Family Health Centers of San Diego • San Diego, CA

Family Health Centers of San Diego’s 40 year commitment to supporting the most vulnerable members in our community has positively impacted thousands of individuals and families. We are proud to continue our mission of caring for all people in San Diego County, but paying special attention to those that have been traditionally underserved. With over 30 locations helping over 125,000 patients in 2012, our mission to exceptionally care for our diverse community is one that is as important to our organization as it is to the many people we care for.

Due to our growth, we are in need of exceptional Psychiatrists to significantly assist our growing organization to further our commitment to the community by providing top-notch care to those who trust in our support. Our commitment to our employees is reflected in our competitive salary as well as our robust benefits package.

Our Psychiatrists will greatly impact our organization’s mission by providing much needed psychiatric services to our patient population of children and adolescents. These services will include assessment/evaluation, diagnosis and treatment of mild to severe mental conditions.

Requirements:
- Board Certification in Psychiatry a plus.
- Graduate from an accredited school of medicine and completion of at minimum a 3-year residency in General Psychiatry.
- Must maintain current CPR and DEA registration
- Must possess current unrestricted license to practice in the State of California.
- Unrestricted California Driver’s license with appropriate transportation and valid insurance, some travel necessary.

Practice Setting:
- CMHC
- Managed Care Organization

Submit Applications To:
John Palmer
823 Gateway Center Way, San Diego, CA 92102
Phone: 619-906-4604 • E-mail: johnp@fhcsd.org
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AACAP News

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For any/all questions regarding advertising in AACAP News contact communications@aacap.org.

COMMUNITY CHILD & ADOLESCENT PSYCHIATRIST

The Department of Psychiatry at Children’s Hospital Boston is offering a full-time or part-time community opportunity for a child and adolescent psychiatrist in its community health center, Boston Children’s at Martha Eliot Health Center. We are looking for a physician not just interested in prescribing medicine, but one wanting to join an exciting scholarly multidisciplinary program to provide psychiatric services in a patient-centered medical home. The successful candidate will have board eligibility or certification in Child and Adolescent Psychiatry. This position will include an appointment at Harvard Medical School. Women and minorities are encouraged to apply. Fluency in Spanish is preferred, but not a requisite.

Letter of application detailing relevant experience and a recent curriculum vita should be sent to the attention of Roslyn Murov, MD, Director, Mental Health Services, Boston Children’s at Martha Eliot Health Center, Jamaica Plain, MA 02130 or roslyn.murov@childrens.harvard.edu. Children’s Hospital Boston is an Affirmative Action/Equal Opportunity Employer. We place a strong emphasis on the values of equality and diversity.

Boston Children’s Hospital
"Until every child is well"

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AACAP: Your One Stop for MOC Resources
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Questions? Contact Elizabeth Hughes, Assistant Director of Education and Recertification, at ehughes@aacap.org, or Quentin Bernhard III, CME Coordinator, at qbernhard@aacap.org.
Advocacy Day 2014

Focused on the Future

For more information visit www.aacap.org
or contact Zachary Kahan, Legislative Coordinator, at zkahan@aacap.org or 202-966-7300 ext. 128.