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AACAP’S 62ND ANNUAL MEETING
OCTOBER 26–31, 2015 • SAN ANTONIO, TX
HENRY B. GONZALEZ CONVENTION CENTER & GRAND HYATT SAN ANTONIO

WITH THE SPECIAL PARTICIPATION OF
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Cover: Marnette and Lawrence A. Stone, MD, AACAP Past President, John Fayyad, MD, and Paramjit T. Joshi, MD, AACAP President, at the Lawrence A. Stone, MD Plenary: “Conducting Research and Interventions for Children in Developing Countries: Challenges and Opportunities.” Dr. Fayyad, MD, Associate Professor of Clinical Psychiatry at the University of Balamand in El-Koura, was the plenary speaker. Dr. Fayyad flew in from Beirut, Lebanon, to present the plenary.
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

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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PRESIDENT’S MESSAGE

Thank You to Gaye Carlson, MD, AACAP’s Program Chair 2011-2014, and Bennett L. Leventhal, MD, AACAP’s Deputy Program Chair and Member Meeting Manager 1980-2014

Paramjit Joshi, MD,
AACAP President

This year’s Annual Meeting marked the end of terms for two major leaders in our Academy and I would be remiss to not recognize their many significant contributions, especially with AACAP’s best-in-class Annual Meeting.

Gabrielle (Gaye) Carlson, MD, has done excellent work as the chair of the Program Committee for the last four years. Gaye’s focus as the Program Chair has been to ensure that AACAP provides educational programming that meets the needs of our diverse membership and, also, that the new research presented is clinically relevant to your practices. Based on the high praise I constantly hear about AACAP’s meetings, I think that Gaye has exceeded her goals.

Gaye has been involved with AACAP’s meetings for well over a decade, most notably chairing the Psychopharmacology Update Institute every other year since its inception. She is regularly rated as the top speaker at many meetings and has been the top requested speaker at the Annual Meeting for four straight years.

Gaye is a wonderful colleague with a great sense of humor (see her many ribbons that she wears at the Annual Meeting), as well as a thoughtful clinician and leader. I look forward to continuing to work with her as a member of Council for the next three years.

continued on page 6
Thank You to Gaye Carlson and Bennett L. Leventhal continued from page 5

Bennett L. Leventhal, MD, has been serving AACAP for the last 35 years by overseeing and constantly improving our meetings and CME events. His energy, vision, and contributions are countless. Most notably, Bennett has been the core of our Annual Meeting, ensuring that it is run not only with the highest level of science to push the field forward into the future, but also with careful logistical support so that we can all enjoy the meeting to the fullest. Bennett has also shepherded our monitor program and is a mentor-extraordinaire. The monitor program is the reason that may have prompted many of you to become child and adolescent psychiatrists, and we have Bennett to thank for this welcoming and nurturing initiative. Bennett has also led AACAP’s efforts at managing our relationships with the pharmaceutical industry as it relates to the meeting and has put AACAP at the forefront of other medical societies in carefully overseeing this important area of our profession.

Bennett is truly irreplaceable and a gem in our field, a flawless diamond with the highest clarity. As a member of my International Task Force, I wish Bennett the very best in his role on the international stage and congratulate him on being re-elected to serve another term as the Chair of the Child Section of the World Psychiatric Association.

Please join me in thanking Gaye and Bennett for their service to AACAP. They can be reached at Gabrielle.Carlson@stonybrookmedicine.edu or Bennett.Leventhal@ucsf.edu.
E. James Anthony, MD, FRCPsych (1916-2014)

E. James Anthony, MD, FRCPsych, AACAP President, 1981-1983, renowned child and adolescent psychiatrist, and dedicated member of our AACAP family, died peacefully on December 10, 2014, at the age of 98.

A true giant in our specialty, he served as president of the American Academy of Child and Adolescent Psychiatry, International Association of Child and Adolescent Psychiatry and Allied Professions, the Association for Child Analysis, and the World Association of Infant Psychiatry.

He was best known for his work on resilience invulnerability/risk in children, particularly those whose parents had serious mental illnesses. He was one of two founders of group psychotherapy. A prolific writer, he authored 320 research articles and nine books, many of which were translated into other languages. Dr. Anthony was recruited from England in 1958 to hold the world’s first endowed chair in Child Psychiatry, the Blanche F. Ittleson Professorship at Washington University in St. Louis, Missouri, where most of his longitudinal research was conducted. His work in St. Louis at the Edison Child Study Center included many grants from foundations and the National Institutes of Mental Health.

Dr. Anthony was born in Calcutta, India, and educated in Darjeeling, India, from the age of four and a half by Jesuits before immigrating to England for medical training. He was a protégé and collaborator with S.H. Foulkes, Jean Piaget, Anna Freud, Erik Erikson, John Bowlby, and Sir Aubrey Lewis. Throughout his early career they introduced him to international and cultural aspects of child development.

He attended medical school at Kings College during the Second World War, including delivering babies during the bombings of London. His first assignment as an officer was to work at Northfield Military Center with S.H. Foulkes, dealing with “shell shocked soldiers.” There they started rudimentary group psychotherapy. Later he was transferred to Hong Kong as chief medical officer for Southeast Asia and was charged with setting up daycare centers for Japanese children who survived the Hiroshima bombings. When he returned from the war, he continued his psychiatric and child psychiatric training at the Maudsley Hospital and received the gold medal from the University of London. He was a Fellow of the Royal College of Psychiatry and his numerous lectureships included a standing appointment at the London School of Economics.

He was a senior lecturer at the Hampstead Clinic and received a Nuffield Fellowship to study for a year with Jean Piaget. At the same time his collaboration with S.H. Foulkes on Groups led them to co-author “Group Psychotherapy: the Psychoanalytic Approach,” considered to this day as the bible of group psychotherapy with many reprints including one this year. As a testament to his lasting legacy and expertise, this spring two books on the subject of group psychotherapy contain introductions by Dr. Anthony.

During his presidency of the International Association of Child and Adolescent Psychiatry and Allied Professions, he formed study groups of colleagues from around the world to learn from various cultures about child development and childhood disorders. He initiated this work, led it, and arranged for funding. This effort was the basis of several of his books.

As AACAP president, he continued his commitment to international collaboration with both a joint meeting of AACAP and the association of child psychiatry in Mexico and leading two large groups to China as it was on the brink of opening its borders to the West. He collaborated with future AACAP presidents and co-led exchanges with the USSR. As a result of this effort, for the first time ever, the USSR sent researchers to participate in the AACAP’s annual meeting.

During his AACAP presidency, he formed a study group to mentor, nurture, and support young researchers in the beginning studies of disaster and trauma. He was responsible for the first, of what would later be known as the Presidential Interview at the AACAP Annual Meeting, when he interviewed Joan and Erik Erikson. His appointment to the Work Group on Consumer Issues led to the development of AACAP’s Facts for Families, which have been translated into multiple languages. Also during his presidency, a successful offer was made to purchase AACAP’s current headquarters.

He had a direct impact on many lives throughout his career and maintained a private practice until the age of 90, claiming “I’ve heard it all!” He was also a training analyst. He was a member of the British, St. Louis, Chicago, and Washington, D.C., Psychoanalytic Societies. In 1995, he moved to Washington, D.C., to become director of Child and Adolescent Psychiatry at the Chestnut Lodge Hospital.

He was married to Ethel Frances (Aust) until her death in 1983. They have four children, Sasha Tipper, PhD; Stephanie Rose, MD; Sonia Burnard, PhD; and Bruno Anthony, PhD; and eleven grandchildren and ten great grandchildren.

He was married for 30 years to Virginia Quinn Anthony, former executive director of AACAP, who with her son, Justin Bausch, and her family and the Anthony family, mourn this loss.

A memorial in the Spring of 2015 will pay tribute to Dr. Anthony. In lieu of flowers, contributions can be made to AACAP designated to help establish an international fund in Dr. E. James Anthony’s name.

We will miss his brilliance, compassion, and generosity of spirit.
CLINICAL VIGNETTES

Screaming For Help

Martin J. Drell, MD

"We have a challenging case for you today," started the attending. "It is of José, a ten-year-old Hispanic male, who lives part time, including summers, in Guatemala where his father has a business, and part time in New Orleans. José had bone pain. The parents took him to the doctor in Guatemala who performed acupuncture. When that didn’t work, the doctor diagnosed José with osteomyelitis and started antibiotics. When that didn’t work, he was taken to the ER here and diagnosed with osteosarcoma with widespread metastases. José was anxious and cachectic when I first saw him. His mother was devastated by the diagnosis. I have never seen someone with such anxiety. She is very difficult to talk with and seems in denial about José’s problems. When we talked to her about his need for surgery, her response was ‘if you take out the bone, he won’t be able to grow.’ I wanted to tell her that the issue was not whether he would grow, but if he is going to live! She has problems with everything we do. We told her that he needed an NG tube and she was reluctant. Everything’s a lengthy discussion. I finally convinced her that José needed it. The interesting part is that she has me explain everything to José. Most mothers talk to me and then convey much of the information to their children. This mom doesn’t do that. She has me do all the explaining. She doesn’t help and then she gets upset with what I say. The very worst thing the mom did was turn to me while I was talking to José, and in Spanish said ‘shut up.’ I’ve never had a mother tell me to shut up!

"José just screams. He screams all the time. He screams when we come near him and before we do anything. We don’t even need to be touching him. The mother and José seem to feed off each other’s anxiety. It’s like they have a private language between themselves. When we finally put in the NG tube, José started screaming that he was choking. Then the mom started screaming."

"When mom met with the orthopedists about the surgery, the mom kept repeating ‘don’t worry José, there will be a miracle and you won’t need the surgery. Don’t worry, we must follow God’s path.’ The orthopedist was at a loss as to what to do. After the meeting, he commented to me that this was a ‘difficult case.’ I agreed. Mom talks about miracles all the time. It will be a miracle if he lives. That will be the real miracle.”

The attending’s presentation description seemed to be delivered in one breath. The frustration was palpable. One of the nurses then picked up where the doctor left off.

"It’s confusing. It’s as if they understand what we are saying, but they don’t. The mom is difficult to talk with. She doesn’t cooperate with José’s needs. She refuses his physical therapy, as she says it causes him too much pain. He is in pain, but she complicates everything. He’s on pain medicine. When we came in one shift, we saw José taking something. It turned out that mom had given him some of his previously prescribed pain medications from home. Luckily, he threw up. He could have overdosed. We told her she couldn’t do that. We are now concerned if it’s safe to send José home between treatments. I don’t think the mom will cooperate with his treatment. We had the home health nurses come and visit in preparation for José’s discharge, and mom didn’t cooperate with them. I doubt if she’ll let them in the house.

José is either asleep or screaming. We really haven’t had a chance to talk with him. Mom says that everything is too much for him. We try to get José to do things for himself, but we can’t, as mom is always there. She sits there and rubs his foot. She is there all the time. We tell her that she needs to take care of herself and take a break, but she refuses. She’s always there. She wore the same clothes for three days!"

The affect in the room and the long introduction made me anxious. I was beginning to feel it would take a miracle for me to do anything that would help, and yet, I needed to say something. I began by validating that this was indeed a very difficult case. “The anxiety is as high as any case I remember you presenting to me and, to make matters worse, there is a cycle of mutually reinforcing anxiety in both the mom and the child.” I commented that I was reminded of a folie à deux situation with the mother and the son feeding off each other. “In folie à deux cases, you usually treat the dominant person, who seems to be the mom, and/or separate the less dominant person. In this case, both options are difficult to do.”

I then noted that the team was at a place it often gets to when dealing with anxiety.

“I note that you keep on being logical and assume that the mother and the child will also be logical. That isn’t the case. We are dealing with two hysterical people. Remember that everyone gets anxious and that some anxiety is fine. Remember that anxiety above a certain level can be overwhelming. Remember that high cortisol levels can be toxic to neurons, especially in the hippocampus, which can affect memory. This level of anxiety may be why the mom seems to understand, but doesn’t.
Using non-psychiatric terms, the mom is ‘out of the box’ and we need to figure out how to help her. Are there any other family members who might help? And speaking of the family, there has been almost no mention of father during the discussion so far.”

The social worker took that as a cue to present what she knew of the family. “I know some details, but not much else. Mom doesn’t want to talk to me either and when she does, she is mostly upset and doesn’t answer my questions. Dad spends most of his time in Guatemala taking care of family business. He makes regular trips here, but arrives mostly late on Friday and leaves early Monday, so it’s hard to talk with him. In fact, I’ve never seen him.”

“How about Skype?” I asked.

“There is something about the connection that makes that difficult.”

“Phone?”

“Same problems,” she responded.

I then joked that the father may have the same troubles dealing with the mom and wants to keep his distance. The team laughed and the presenting doctor joked back that she was now “off service” and that another doctor now had to deal with the mom.

“Mom and José make you want to be away from them,” I commented. “Are there any other family that come in who they can talk to?”

“There is a sister-in-law who visits.”

“Is the mom calmer with her? Can she help us deal with the mom?”

“Not really.”

All these negative answers were not necessarily easing my anxiety. I kept asking questions, looking for opportunities to help the team.

“Do we have any idea of whether the mother is like this all the time or has she been overwhelmed by José’s sickness? Do we know what her normal baseline is? To know that would be of help. Hopefully, we will be able to find someone in the family who can be a historian and help us to do a genogram looking for strengths and people who might be enlisted to help. Could the sister-in-law help in providing this information?”

“I’ll try to get that information” said the social worker.

I then addressed the Chaplain. “It’s obvious that religion plays an important part in this case. Have you been able to talk to the mom?”

“I have tried, but really have not been able to talk with her in any meaningful or helpful way.”

“Well, keep trying.” I remarked. “Has a psychiatric consult been called?”

“Yes. It’s not back yet.”

“Well, let’s see what they think. It would be nice if we could help mom and José deal with their anxiety. Perhaps some medications might help?”

“And I assume the psychologists have been consulted to work with José on pain management/stress management?” I asked.

“They have been consulted and report having the same problems we are having,” said the doctor.

Undeterred, I continued to suggest things. “I think that what is most needed is a family intervention. To me, this is an emergency. And that brings me back to the issue of the father. He absolutely needs to be involved! He needs to be part of the process in a different way than he has been so far. There needs to be an emergency meeting scheduled.

“As you presented the case, I associated to the work of Bill Beardsley on families with ‘depressed’ caregivers. He meets with the family. He allows the family to discuss their unique situation and educates them about depression and its impact. He explains that the roles usually filled by the depressed caregiver need to be covered by other family members and supports. A specific treatment plan is then individualized based on their strengths and weaknesses of the family.

“If the family meeting doesn’t work, then I think we need to think about whether the situation is significant enough to be reported as medical neglect. The mother is getting in the way of appropriate treatment of her son. She is passively causing problems by what she doesn’t do that she should, and actively causing problems by doing things that she shouldn’t, like with the pain meds and her rejection of and interference with suggested treatments. This is a medical emergency. Do you agree?”

With this, the team noticeably calmed and agreed with the plan. Their response, in turn, calmed me. After throwing out many suggestions, one seemed to be of help to the team. They logically discussed how to contact the father and how to set up a meeting as soon as possible. As I rose to leave the meeting, I let the team know I was available to help and would follow-up on the psychiatric consult. And as I often end such consultations, I joked, “And next time, be sure to present me with a difficult case!”

References
Can an international exchange of ideas broaden AACAP members’ understanding of Attention Deficit/Hyperactivity Disorder (ADHD)? Past-president Marilyn Benoit, MD, and I went to Durban, South Africa, in August 2014 to see. Under the sponsorship of the Association of Child Psychoanalysis, I organized a multinational, multidisciplinary panel at the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) to explore the phenomena of ADHD from psychoanalytic, psychiatric, infant mental health, developmental, pediatric, and public health points of view from both the United States and South Africa. The panel found the conception of ADHD as primarily a neurologic disorder to be simplistic and overly reductionist.

Astrid Berg, MD, from her perspective as a child and adult psychiatrist in Cape Town and member of the Board of Directors of the World Association for Infant Mental Health, viewed the ability to effectively regulate emotions as a fundamental requirement for early social development and reminded us that it is within the first relationships that infants learn to direct attention and develop self-control. Disturbances in these attachment relationships may manifest with symptoms of hyperactivity and impulsivity during toddlerhood. Labeling such children with “ADHD” may lead to the avoidance of examining environmental and relationship influences, which may play a critical role in shaping the child’s behavior. In support of these observations, she presented a dyadic clinical case “The Hyperactive Toddler,” which beautifully illustrated a desperate child’s hyperactive behavior as a means to seek maternal responsiveness. Dr. Berg considers ADHD to frequently be an “Attachment Deficit Hyperactivity Disorder” syndrome.

Helen Clark, MD, is a child psychiatrist from the Child, Adolescent, and Family Unit at Chris Hani Baragwanath Hospital in Soweto, Johannesburg, South Africa, which she has headed for seventeen years. She spoke of the importance of recognizing the mental health needs of children under age six, since most neuro-developmentally based disorders begin to emerge at that time. Such children present with delays or deviance in their expected development and with aberrations of behavior, which become their way of engaging their environment. The impact of these problems is most likely to be felt in situations where socioeconomic deprivation, child abuse, overcrowded dwellings, and unstructured schooling prevail; and in which the impact of these behavioral challenges is exacerbated through punitive parenting, exclusion from school settings, and impaired exposure to healthy developmental influences. Six years ago, at her hospital in Soweto, Dr. Clark and her colleagues decided that the evaluation and management needs of these children and their caregivers would be best served by establishing a monthly clinic, which has handled around 500 children. Their clinic addresses the medical and developmental evaluations of these children within the context of their homes, families, and communities, and provides medical intervention and a diagnostic children’s group in parallel with parental group counseling. This presentation was her first presentation of the cumulative data and experience gained through her work in the impoverished Soweto population.

Dr. Benoit presented a contrasting situation in the United States, expressing her concern about the extensive use of questionnaires as a major diagnostic tool without adequate attention to history and the child’s interactions with parents and family. Depending on a checklist of possible ADHD symptoms may lead to inaccurate diagnosis and incentivize the use of medications. Since positive

“The panel [at the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP)] found the conception of ADHD as primarily a neurologic disorder to be simplistic and overly reductionist.”
primary parental relationships are crucial for early wiring of neural networks and, therefore, of self regulation. Emotional and physical traumatic injuries, from early separations to brain injuries, may affect the brain's executive functioning and give rise to symptoms that mimic ADHD. Additionally, sleep disorders, depression, and posttraumatic stress disorder (PTSD) can present with these symptoms. Dr. Benoit maintained that correcting these problems with a pill is simplistic. The use of medications may suppress symptoms but they do not by themselves promote development. Instead, clinicians must accurately define a child's more complex environmental and functional problems in order to craft an appropriate intervention and treatment plan. And, wisely, she added that although child and adolescent psychiatrists are pressured by the pharmaceutical companies to prescribe, it is the responsibility of each physician to prescribe judiciously and with a full awareness of the limitations of medicating.

The three psychoanalysts on the panel, Anne Carter, MD, from Austen Riggs Hospital in Massachusetts, Stephanie Smith, MA, MW, president of the Association for Child Psychoanalysis, and Nathaniel Donson, MD, also emphasized the risks of intervening rapidly with medication to make symptoms of distractibility and hyperactivity disappear while failing to assess and treat the external and internalized difficulties that generate the symptoms. Citing the work of Robert Furman, they emphasized that young children have limited ways to either avoid or express emotional distress or to ward off intolerable conflicts. Young children will tend to: 1) withdraw into fantasy (distractibility and lack of focus), 2) express distress through motor activity rather than verbalization (impulsivity and hyperactivity), and 3) experience rage outbursts (irritability).

The psychoanalytic perspective questions the likelihood that ADHD, as defined in the DSM, is the result of a simple neurological disorder. Rather ADHD is approached as a symptom complex that can stem from a multiplicity of early-life determinants, some of which may be constitutional, e.g., neuro-cognitive reality sampling deficits, sensory integration disorders, learning disabilities, auditory and visual processing disorders, and executive functioning disturbances. Equally important are psychological determinants, e.g., internal representations of disorganized and anxious attachment relationships, or the internalization of trauma and the developmental status of the child. Social determinants include a wide variety of adverse early-life experiences, e.g., emotional and physical neglect and abuse, domestic violence, parental mental illness, etc.

Dr. Carter, in her clinical work, insists upon seeing dysregulated children with their parents, observing the dynamic family process so as to correctly diagnose her child patients relationally, as well as individually. Ms. Smith presented material from the psychoanalysis of a five-year-old boy, exploring the meanings of ADHD symptoms from a psychoanalytic point of view. Her case presentation illustrated how symptomatic surface symptoms are internalized, become represented from the inside, and influence the ways that others and the world are understood. She discussed viewing ADHD symptoms in a broader context within self and other relationships, reflecting on their impact on self esteem and contributing to the way the child makes meaning in their emerging world.

At this conference, I took the most radical stance in the de-construction of the ADHD diagnosis. I pointed out that “ADHD,” used as a primary diagnosis, has no etiologic or pathogenic significance, is conceptually and diagnostically distracting, leads to a paucity of thinking about a patient’s early developmental history and possible trauma, and is therapeutically misleading. I further emphasized that childhood ADHD labeling shifts our clinical focus away from intra-psychic (psychodynamic) considerations of defense, affect, and conflict, and represents a profound loss to considerations of our patients’ inner lives. My doubts about ADHD as a useful diagnosis began with the fact that in over forty years – in my office practice, at former agency jobs, and at the agency where I have taught, supervised, and done psychiatric evaluations for fifteen years – I have never seen a “pure” case of ADHD.

Dr. Donson is in the private practice of psychiatry and psychoanalysis in Englewood, New Jersey; is a liaison member for the Association for Child Psychoanalysis of AACAP’s Psychotherapy Committee; and on the faculties of the Columbia (New York) Psychoanalytic Center for Training and Research and the Institute for Infant and Preschool Mental Health in East Orange, New Jersey. He may be reached at MNDonson@aol.com.
Seclusion and Restraint Column becomes “Acute Care” Column.

With this issue, the Seclusion and Restraint column expands its domain to include all aspects of child and adolescent care that occur in acute-care settings, such as emergency rooms, inpatient facilities, and residential-care settings. The intent is to cover in AACAP News an area that until now had no designated home, despite its importance in managing individual and family crises.

The column solicits contributions from AACAP members who would like to share experiential observations, wisdom, or academic issues related to acute care. If you would like to share your knowledge with the readership, please consider this an open invitation. Columns are up to 1,000 words and follow the AACAP News Mission, published in each issue. In the fall 2014 online issue of JAACAP Connect, Editor Andres Martin, MD, urged readers to consider submitting articles to a variety of outlets as part of their clinical experience. This column is one such forum that is eagerly looking for contributors (Martin 2014).

Please send submissions to Kim Masters, MD, the column coordinator, at kimmasters@brontosaur.org.

Non-suicidal self-injury (NSSI) cutting, abrading skin with erasers, and burning with flame or cigarettes are frequent in adolescence, and they are often a symptom of negative self-image and a focus of therapy. Some alternatives to NSSIs have focused on using rubber bands or ice as distractions. Temporary tattooing may also serve this purpose, as well as challenging the perception that body image is enhanced by self inflicted cuts and abrasions (Muehlenkamp 2005; Carroll 2006). In a study of 423 individuals who used body enhancements (tattoos and piercings), 27% admitted to cutting themselves during childhood. The study authors concluded that the body enhancements became a substitute for self-harm, helped cope with traumatic life experiences, and improved satisfaction with body image (Strim 2008).

Findings

The most common diagnoses of our self-harm patients included mood disorders, usually comorbid with borderline or narcissistic personality disorder. Female patients were more common than males.

The conversational atmosphere around self-harm changed. Instead of an explanation of the reason for a self-injury incident, adolescents were encouraged to discuss the meaning of their tattoos. Some of the previously noted commentary from these adolescents included: using tattooing to manage flashbacks of previous sexual abuse; using tattooing to substitute for self-injury caused by relationship conflicts, rejections, and ruptures; using tattoos to repair negative body image resulting from abuse experiences.

Some examples of tattoos included vines, roses, and other flowers; two faces showing relationship conflicts; foreign words, especially Chinese and Japanese symbols to indicate secrecy messages of strength or alienation; fused hearts showing attachments; day dreams represented as dolphins and unicorns; two flags representing living in two cultures; and words that triggered intense feelings such as personal names and “love.”

None of the tattoos reflected negative perceptions such as feeling ugly or self-hatred, possibly because the adolescents were introduced to this strategy when they were not imminently going to injure themselves, and because the designs promoted a sense of self-efficacy.
Failures
Patients who had been cutting on themselves for several months often failed to use the markers and draw on themselves, and self-harmed instead. Their reasons included not thinking about alternatives or preferring to hurt themselves. Our response was to have them draw a tattoo either super imposed or adjoining a self-injury site. We hoped that the direct comparison of two ways to handle distress would lead to a shift from self-injury to pride in self-expression with body enhancement. Over several months of our persistence with this strategy “tattoo/don’t cut,” we found attenuation and then cessation of intentional injury behavior accompanied by a more realistic and enhanced self-image.

Use with Psychotherapies
Because of its visual and physical properties, we were able to incorporate temporary tattooing into several psychotherapeutic approaches. It served as part of the EMDR (eye movement desensitization and reprocessing) safe place, the safety skills of TF-CBT (Trauma Focused CBT), as an element in Mindfulness and Meditation, and as a component of the wise mind in DBT (Dialectical Behavior Therapy). It also was an element of support in family therapy by giving family members concrete visual examples to support their children’s self-image.

Other Examples
“The Blue Butterfly” as described by one adolescent is used in at least one North Carolina setting. This Lepidoptera tattoo or decal is placed over a site of self-injury in order to forestall future attempts by warning of fatal consequences for the butterfly. This thinking assumes that a teenager would be bothered by the death of an imaginary insect. However, since this idea was reported to me by an adolescent who claimed it was an effective self-harm preventative strategy, evidently some teenagers are more sensitive to the imaginary killing of the vulnerable than in the actual self-inflicted injury.

In fact, we found decals to be useful substitutes for those who do not have confidence in their drawing abilities. Like marker drawings, they could be readily replaced depending on changes in mood or interest. We found that pre-adolescents often started out their tattoo experiences with them.

We do not know whether the tattoos themselves or the psychological atmosphere in which they existed was the therapeutic treatment element. We also do not know whether they will lead to permanent tattoos and associated potential long-term negative consequences such as social stigma. However, we can say that the use of temporary tattoos for the prevention of self-harm is effective in the immediate circumstances when they engage the interest and creativity of the adolescent, the therapist, and the family.

References

Dr. Masters is medical director at Three Rivers Behavioral Health Services Midlands Campus Residential Treatment Center and adjunct professor in the Physician’s Assistant Program at the Medical University of South Carolina. He may be reached at kimjmasters@brontosaur.org.
“Historical Trauma of the Original Peoples of North America (Canada)”

Tim Beal, MD

“First Nations” is the commonly used name for the original peoples of North America that Canada and the United States have historically called “Indians.” The Canadian constitution recognizes three groups of “Aboriginal people:” Indians, Métis, and Inuit. According to the 2011 National Household Survey, about 850,000 people identified as a First Nations, representing 2.6% of the total Canadian population. About 75% of this group is registered as such with the Canadian Government. However, these numbers are an under representation, as many First Nations chose to not participate in the Survey.

The Traditional Ways

The terms “Traditional Knowledge” or “Ways of Knowing” refer to information passed from generation to generation, not only through storytelling, but also through traditions, ceremonies, medicines, dances, and art. This knowledge is also stored in the physical body of First Nations and is passed down through bloodline. “Blood memory” refers to the innate ways of knowing that exist in the DNA of First Nations people. Traditional knowledge is determined by a people’s land, environment, region, culture, and language. First Nations believe that their values and traditions are gifts from the Creator. People give thanks to everything in nature, upon which they depend for survival and development as individuals and as members of their communities. First Nations treat all objects in their environment, whether animate or inanimate, with the utmost respect. Some societies are matriarchal while others are patriarchal. In both systems, women are held in high regard as the givers of life.

Many First Nations view health or “wellness” as a balance between four domains of Body, Mind, Emotion, and Spirit. Each domain must be nourished in equal amounts or else illness develops. Connection to the spiritual world is integral to the traditional ways of life. Like the seasons, life is circular and time is always in flux. Life and death do not represent a beginning and an end; they represent the transition from and back into the Spirit World.

“Suicide rates are five to seven times higher for First Nations youth than for non-Aboriginal youth.”

Contact: Trading and Military Alliances

First Nations peoples were crucial to early European explorers’ survival in unfamiliar territories. Explorers, fur traders, and soldiers followed the First Nations trade routes inland and established a network of forts and posts to recognize and trade with First Nations partners. As French and British colonies expanded and competed, military alliances with First Nations were forged that brought much needed support to both camps. With the Treaty of Paris in 1763, Britain became the primary European power throughout much of North America and recognized that the success of their colonies depended upon stable and peaceful relations with First Nations. King George III issued a Royal Proclamation in 1763, which specified that only the Crown could negotiate the purchase of land from a First Nation.

Relocation

With the end of the War of 1812 and the influx of settlers, First Nations were increasingly viewed as an impediment to growth and prosperity rather than valuable military allies and trading partners. Settlers began to pressure the colonial administration for the lands held by First Nations and the ensuing land surrender treaties did not create sizeable reserves. By the 1830s, only pockets of First Nations lands remained and relocations often involved moving widely dispersed or different populations into a common community.

Broken Treaties

With continued colonial expansion and the eventual Confederation of Canada in 1867, many of these original treaties and rights were infringed upon. According to the Report of the Royal Commission on Aboriginal Peoples (1996), treaties and other agreements were, by and large, not covenants of trust and obligation but devices of statecraft, less expensive and more acceptable than armed conflict. Treaties were acknowledged formally but ignored frequently.

Indian Act 1876

In Canada, the “Indian Act” has the primary piece of legislation designed to assimilate and dispossess Aboriginal peoples recognized under the Act. The Act gave greater authority to the federal Department of Indian Affairs to intervene in a wide variety of internal band issues and determine who was an “Indian.” The Department would also manage First Nations lands, resources, and moneys; control access to intoxicants; and promote “civilization.”

The Act aimed for the whole-scale abandonment of traditional ways of life, introducing outright bans on spiritual and religious ceremonies such as the potlatch and sun dance. According to
the Report of the Royal Commission on Aboriginal Peoples (1996). Aboriginal people were believed to be inherently inferior and incapable of governing themselves and that wardship was appropriate for Aboriginal peoples, so that actions deemed to be for their benefit could be taken without their consent or their involvement in design or implementation.

The Indian Act has also been criticized for excluding women from their First Nations rights. Legislation stated that an Indian woman who married a non-Indian man would cease to be an Indian. She would lose her status, and with it, treaty benefits, health benefits, the right to live on her reserve, the right to inherit her family property, and even the right to be buried on the reserve with her ancestors. However, if an Indian man married a non-Indian woman, he would keep all his rights.

Residential schools

Between 1857 and 1996, over 150,000 Aboriginal children were removed from their homes and communities and placed in the care of strangers, whose job was to “civilize” them in the ways of the dominant European, Christian society. Children were forced to abandon their traditional languages, dress, religion, and lifestyle. Many were inadequately fed, clothed, and housed. All were deprived of the care and nurturing of their families and communities. Tragically, some of these children died in these schools and others never returned home. Residential schools systematically undermined Aboriginal culture across Canada and disrupted families for generations, severing the ties through which Aboriginal culture was taught and sustained, and contributing to a general loss of language and culture. The last residential school closed in 1996.

In June 2008, the Prime Minister of Canada issued a formal apology to the victims of residential schools in Canada … “The government now recognizes that the consequences of the Indian Residential Schools policy were profoundly negative and that this policy has had a lasting and damaging impact on Aboriginal culture, heritage, and language. While some former students have spoken positively about their experiences at residential schools, these stories are far overshadowed by tragic accounts of the emotional, physical and sexual abuse and neglect of helpless children, and their separation from powerless families and communities. Not only did you suffer these abuses as children, but as you became parents, you were powerless to protect your own children from suffering the same experience, and for this we are sorry.”

Sixty’s Scoop

The term Sixties Scoop refers to the mass removal of Aboriginal children from their families into the government’s child welfare system. The justifications for removing children from their homes were largely due to cultural differences in parenting practices that were misunderstood as neglect by non-Aboriginal social workers or due to poor living conditions caused by governmental underfunding of essential services on-reserve. Most of these children were placed without the consent of their families or Nations into non-Aboriginal families. By the 1970s, roughly one-third of all children in care were Aboriginal. Aboriginal children remain over represented in the welfare system today. Many scholars refer to this time period as a continuation of the residential school system through which First Nations children were again stripped of their native culture and beliefs.

Historical Trauma

Over the past 500 years since contact with Europeans, the First Nations people have suffered severe physical, mental, emotional, and spiritual injuries. First Nations people lost much of their land and resources, their language, their rituals and customs, their traditional wisdom/knowledge, their religion and spirituality, their community, their families, and individual lives.

Dr. Maria Yellow Horse Braveheart has conceptualized historical trauma as “the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma.” The effects of historical trauma include: unsettled emotional trauma, depression, high mortality rates, high rates of alcohol abuse, significant problems of child abuse, and domestic violence. As a group, First Nations people live more impoverished lives than the general population and suffer from higher rates of suicide, depression, post-traumatic stress disorder, and solvent abuse and binge drinking. Suicide rates are five to seven times higher for First Nations youth than for non-Aboriginal youth.

Historical Trauma is epidemic in Canada’s First Nations communities. Healing from any form of trauma often depends on the presence of factors that promote resiliency, most of which were systematically destroyed through the events described above. Worse yet, what actually worked for the First Nations for thousands of years was continued on page 16
nearly extinguished through the process of assimilation. Generations of children were taught that their spirituality was evil, that their language was useless, that their customs were inferior, and that their parents were inadequate. As a result of the residential school system, many are still fearful of traditionalism. And further, the historical oppression of First Nation’s people has created a high level of mistrust that precludes many from seeking out western “mainstream” services.

Thankfully, blood memory and some keepers of “The Way” have survived. First Nations communities in Canada are becoming stronger and passionately resurrecting the traditional language and ways of life. Time is always in flux and seasons change. After 500 years of a brutal and harsh winter, it seems that signs of a new spring are slowly arriving.

Special thanks to my strong Anishnawbe Kwe friends and mentors, Liz Akiwenze and Lisa Martin, for their knowledge and guidance. Liz is Ojibway and Oneida from the Cape Croker First Nation. Her spirit names are “Understanding Woman” (Ojibway) and “She who reasons and she who sees both sides” (Oneida). Lisa is Ojibway/Potawatomi from the Chippewas of Kettle and Stony Point First Nation. Her spirit names are “Morningstar” and “The day the Wind Spirit came and introduced itself.”

References


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COMMUNICATION COMMITTEE

Boundary Issues in the Age of Increased Communication, Collaboration, and Multiple Roles

Gail A. Edelsohn, MD, MSPH, Joseph Jankowski, MD, and Kristen M. Lambert, Esq., MSW, LICSW

The lives of children and adolescents are interrelated with the lives of their parents or caretakers, and frequently may involve multiple systems, such as family, education, health care (physical and behavioral), child welfare, the court system, and funding sources. With proper consent, a child and adolescent psychiatrist may gather information from a variety of sources during evaluation and treatment. And, it is common for the child and adolescent psychiatrist to find him or herself in various roles and settings, e.g., acting as the treating therapist/psychiatrist, collaborating in a split care model, being part of a co-occurring or integrated care/behavioral health model, or consulting to a school, child welfare system, juvenile justice or the court; or in the role of clinician/administrator/researcher/supervisor. These roles and settings provide unique and rewarding opportunities for child and adolescent psychiatrists. However, the complexities of the relationships also may create circumstances that enhance the risk of boundary crossings and boundary violations. High profile cases of sexual boundary violations generate headlines and can lead to significant repercussions for all involved (patient, family members, physician, and colleagues). However, there are other types of boundary crossings and violations that may have the same potential for negative impact yet escape detection until actual harm has occurred.

Glen Gabbard, MD, has published extensively on the distinctions between boundary crossings and violations (Gutheil and Gabbard 1993; Gabbard et al. 2012). This column summarizes Dr. Gabbard’s work and lists factors that may enhance awareness of boundary issues, provides several short illustrative vignettes with some brief commentary as to key ethical principles, describes potential consequences of boundary violations, and offers risk management tips and recommendations (AACAP Code of Ethics 2009).

“Boundary violations are the opposite and are described as “exploitive breaks in the frame;” are repeated, offensive, and typically are off limits for discussion in therapy; and most often cause harm to the patient and/or the treatment (Gabbard et al 2012).

The following factors should be considered as they may impact the likelihood of boundary issues in the psychiatrist’s relationship with the parents and caregivers, as well as with representatives of child serving systems (e.g., health, education, court, child welfare):

- How involved is the adult with the child’s treatment and psychiatrist?
- What is the current role of the adult in the youth’s treatment (parent, case worker, teacher providing collateral information, noncustodial parent or family member)?
- What is the frequency of the adult interface with the psychiatrist?
- What is the psychological well-being (or difficulties) of the adult involved in the child’s treatment?
- Does the adult have a specific agenda (e.g., to remove the child, gain custody, obtain additional services, etc.?)
- Intrapsychic issues (transference) of adult with the child’s psychiatrist and countertransference of the psychiatrist towards the adult or child and adolescent patients.

Additional factors in the clinical setting that may increase the vulnerability for boundary issues:

- Divorce, custody, and marital issues;
- Medical issues related to the parents/guardians;

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In this age of increased communication, collaboration with multiple caregivers and other interested parties has become common practice, making careful attention to ethical issues critical.”

More than two decades ago, Drs. Gutheil and Gabbard’s conceptualization about boundaries led to a framework of boundary crossings and violations that sparked a rethinking of daily decisions and emphasized the importance of clinical context in determining if such crossing is helpful, neutral, or harmful (Gutheil and Gabbard 1993). In 2012, Gabbard et al. revisited the issue and summarized the distinctions. Boundary crossings are characterized as benign, even helpful in therapy; typically occur in isolation; may be addressed in therapy; and, in the end, do not cause harm to the patient (Gabbard et al. 2012).
Boundary Issues continued from page 17

- Educational issues; and
- Vulnerable parents/guardians.

Case 1: Dr. A (a child and adolescent psychiatry resident) is treating the 9-year-old son of a single mother. The boy’s sister, a victim of incest by the father, is treated by another doctor in the clinic. The mother is bilingual and is thrilled to learn the resident speaks her native language. In supervision, the resident anxiously shares that the mother has called a few times asking that he meet her to bicycle in the park to discuss her son’s difficulties and the importance of a male figure in her son’s life.

**Key Points: Developmental perspective and beneficence.** If the resident met with the mother outside of the therapy, how would it impact the boy’s relationship with his mother and how would it advance or impede the treatment? Professional boundary considerations such as time, place of appointment, and minimizing harm should be considered; as well as the heightened risk of evolving into an inappropriate relationship.

Case 2: Dr. B is performing a court ordered evaluation of a 13-year-old female who was charged with making terroristic threats, selling drugs, and theft. The child’s mother retains primary custody; however, the state child welfare agency is involved. After obtaining consent to review the child’s educational testing and academic records, her teacher calls and begs Dr. B to give a favorable recommendation to the court, as she is a “really a good girl.” At the end of call, the teacher says to Dr. B, “Remember, last year I cut your daughter a break on her final grade.”

**Key Points: Confidentiality.** Consent was obtained to review testing and academic records. However, no release was obtained to talk with teacher, or to reveal the patient was being evaluated. The teacher’s comment about the doctor’s daughter raises the issue of conflict of interest and dual roles.

Case 3: Dr. C provides psychiatric consultation to a pediatrician, Dr. D, in a medical home model setting. Dr. D knows Dr. C’s interest in autism and offers him free tickets to the autism golf classic fundraiser. Dr. D adds, “Besides, it will give me a chance to pick your brain about my son as I am worried he’s on the spectrum.”

**Key Points: Dual roles, potential perils of curbside consultation with a colleague, issues of privacy and confidentiality.** The free tickets raise the question of how to handle a gift, and the ethical principle of professional rewards.

**Potential Consequences**

The consequences of boundary violations for the child or adolescent may include disruption of treatment with likely termination, loss of the relationship with the therapist, feeling of being deceived, and difficulties with trusting another doctor. Depending on his or her role, an involved adult may express grief and anger over the loss of the relationship, blame him or herself and/or the psychiatrist, or file a complaint or bring a suit against the doctor. The psychiatrist may be investigated by the licensing board of medicine; have his or her license revoked, restricted, or suspended; be required to enter a program for impaired physicians; and may lose their position. In addition to these professional losses, the psychiatrist’s family may also be impacted, as there could potentially be unwelcomed media attention and the psychiatrist may lose the privilege of membership in local and national professional groups.

**Risk Management Tips**

Although not an exhaustive list, here are some risk management tips to keep in mind:

- **When treating patients, ensure that proper consent is obtained from the legal guardian.** This is important if you are interacting with other providers. Each state may have differing regulations regarding privacy of records, particularly mental health and substance abuse records. In addition, some states have differing age of majority for mental health treatment. It is important that you are aware of the regulations applicable to you.
- **Boundary violations may result in legal issues.** There also may be applicable regulatory mandates or guidelines. Should you have questions on an issue involving a potential boundary crossing/violation, contact your attorney or risk management professional at your professional liability insurance carrier.
- **Consider seeking consultation for boundary issues from an experienced clinician.** Try to be open minded to the consultation even if it results in termination and referral of the patient (Schetky 1995; Pope and Keith-Spiegel 2008).
- **Consider termination and potentially arrange for the transfer of care.** Many states have regulations for termination (for example, regulations requiring notice and the time frame for termination). However, some states also may have regulations concerning immediate termination. It is important that you are aware of the applicable rules within your state.
- **It is important to document the termination within the medical record and retain a copy of the written termination letter sent to the patient.** Interpersonal conflicts may not, however, need to be documented in the medical record. Again, should you have questions, contact your attorney or risk management professional.

**Conclusion**

In this age of increased communication, collaboration with multiple caregivers and other interested parties has become common practice, making careful attention to ethical issues critical. Boundary crossings and boundary violations may
have a negative impact on the patient, the patient’s family, other caregivers, and the psychiatrist. AACAP members need to have enhanced awareness of the increased number and variety of boundary issues that may confront them in their daily work and better understand where to look for answers to their ethical questions.

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Ms. Lambert is vice president of Risk Management, AWAC Services Company, a Member Company of Allied World Assurance Company Holdings, AG. Allied World is the AACAP-sponsored carrier through its strategic relationship with the American Professional Agency, Inc.

References


Disclaimer: This column reflects the professional opinion of the writers and the AACAP Ethics Committee and Member Benefit Committee. It is meant to be educational and should not be construed as legal, technical, or clinical advice. Consult your professional advisors or legal counsel for guidance on issues specific to you. Each clinical, research and administrative situation is unique; and each state has different rules and regulations governing medical practice.

AMA Adopts New Policy Curbing Solitary Confinement of Juveniles in Correctional Facilities

KUDOS to Lou Krauss, MD, and our entire AACAP/AMA Delegation for their collective efforts in helping make this new policy a reality!

At the American Medical Association’s Interim Meeting in November, the AMA, with help from our delegation, called for correctional facilities to halt the isolation of juveniles in solitary confinement for disciplinary purposes. The new policy supports restricting the use of isolation in juvenile correction facilities for only extraordinary circumstances when there is an acute risk of harm to self or others.

“Recognizing the harmful physical, emotional and psychological impact of solitary confinement can have on the health of prisoners, the AMA will oppose solitary confinement as a punishment in juvenile correction facilities,” said AMA Board Member William E. Kobler, MD.

The policy also stresses that the isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
Starting a Private Practice: Finding What You Need on the AACAP Website

Taking the leap into private practice can be incredibly daunting. In preparation for becoming an early career psychiatrist (ECP), training programs may have provided much support in learning to develop a business model, create standards of evaluation, and continuing care in a solo practice. Some programs provide strong mentorship with psychiatrists at various training levels who are successfully managing either part or full time private practice. However, most graduates would admit they feel under prepared to open a private practice on their own. From managing the business end of a burgeoning practice to learning about electronic medical record to choosing forms with which to track patient symptoms and response to your treatment, numerous tasks await an ECP. As an early career psychiatrist, two years out from graduation, my confidence level in opening my own practice was tenuous, to say the least. Luckily, AACAP’s website has numerous resources to support members opening a practice, just go to www.aacap.org and explore Member Resources.

One resource that I found especially helpful was the AACAP Toolbox for Clinical Practice and Outcomes, which can be found on the Academy’s website in the Member Resource section (Munetz 1988) and contains documents that any child and adolescent psychiatrist can use to establish a well running clinical practice. From extensive intake forms to medication consent forms and rating scales to assist with diagnosis and ongoing treatment and monitoring, this toolbox should be a “favorite” webpage for all ECPs. One of the most valuable tools I found while browsing was the Child and Adolescent Psychiatry Practice Telephone Intake, which allowed me to customize how I screen patients and quickly identify families’ areas of need. Also customizable is the Request for Medical Records form, available on the website in the Toolbox.

Also, critical scales are available, such as the Abnormal Involuntary Movement Scale (Munetz 1988), the parent and child versions of the Screen for Child Anxiety Related Disorders (Birmaher et al. 1997), ADHD scales such as the SNAP IV (Swanson 1992), as well as medication consents specific to medication class. Simple forms provide practitioners with ways to track side effects, efficacy and self-report of remaining symptoms.

The Toolbox is just one area of AACAP’s website that can assist anyone starting a practice. The Clinical Practice Center educates about the business side of practice with key webinars ranging in topic from expected changes with the Affordable Care Act to internet professionalism. Refreshing your knowledge on a disorder through the website can also provide Continuing Medical Education credits. Hundreds of academic articles on every psychiatric topic are available to members with online access, not only to the Journal of the American Academy of Child and Adolescent Psychiatry, but also in the Member Resources section to Child and Adolescent Psychiatric Clinics of North America. The AACAP Practice Parameters are at your fingertips through a quick link from the Home page, guiding your patient care with the most recent recommendations from AACAP.

There is even a guide to becoming voluntary clinical faculty at an academic institution to expand your ability to teach and supervise trainees under Early Career Psychiatrists, Career Planning in Child and Adolescent Psychiatry, Professional Development.

AACAP provides its members with a link to special rates on malpractice insurance and provides guidance on risk management, documentation of patient care that meets current coding requirements and even mentorship opportunities. Experts provide guidance on becoming versed in electronic medical records (EMR) and how to choose an EMR for your practice. For families, this Toolbox allows for a link to the National Alliance on Mental Illness handbook for parents. And you can download AACAP’s Facts for Families from the website—a clear and quick reference for your patients and families on more than 100 mental health related topics and are a terrific way to

Stephanie Hartselle, MD
reinforce office psychoeducation on various disorders.

The Toolbox is available from the Member's Only section of the website. You'll need your login ID and password. From the Home Page, go to Member Resources, click AACAP Toolbox for Clinical Practice and Outcomes and click Enter the Toolbox. From there you will be able to navigate through the forms available to all members.

If you are overwhelmed with all that needs to be done to start and maintain a practice, start with AACAP’s Toolbox for Clinical Outcomes and Practice. Once you have gotten comfortable with it, take a tour around the Clinical Practice Center. I suspect you will be pleased and surprised by the wealth of resources available to help you in starting or enhancing your practice. AACAP is here to partner with you, providing support to psychiatrists at any career stage.

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Nominations for AACAP Officers and Council Members: Why You Care

Passionate about your career? Want an AACAP that can support you and your profession into the future? One way to help ensure this is to NOMINATE (i.e., help in the selection of) diverse, talented, and experienced members to serve as leaders of our organization. The other way is to VOTE when elections come up each spring.

This brief article reviews how the nomination and selection processes work. Any General Member or Distinguished Fellow of AACAP can nominate as many people as they would like (including themselves) for the positions of President-Elect, Secretary, Treasurer and Council Member-At-Large. You can best nominate people by sending an email to the Nominating Committee (Executive@accap.org). Nominations can be sent at any time during the year but, to be considered for the spring election, must be received before February 1 of each year. You can tell us why you think this person or persons would be good candidates for the job, or you can simply submit their name. Either way, the Nominating Committee will consider all nominations submitted.

The Nominating Committee consists of four AACAP members and chaired by the Immediate Past President. Council selects the Nominating Committee candidates and elected by AACAP’s membership. Each committee member serves a two-year term. Members of the Nominating Committee cannot be nominated for any office themselves while serving on the committee.

The Nominating Committee will meet in February, at which time we will review all of the persons nominated by AACAP members. The committee has a semi-structured way of reviewing candidates, which includes consideration of experiences within AACAP (assembly, council, committee member or chair, task force member, etc.), diversity (age, ethnicity, gender, sexual orientation, geographic area, rural vs. urban, academic vs. private or public sector, professional area of expertise), ability to engage well with colleagues, and other experiences pertinent to the position (public speaking, writing skills, budget experience, e.g.). The committee takes this task very seriously and respectfully, and will try to find the best two candidates for each position to present to the membership for voting.

Once the Nominating Committee rates their list of top candidates, the committee chair calls candidates in descending order, eliciting from them their level of interest and whether they have any conflicts of interest that may be problematic. Once two candidates for each position are identified and are willing to serve, those names will be placed on the ballot. In addition to the candidates that the Nominating Committee presents, the name of any eligible member supported by a petition signed by 5% of the voting membership will also be added to the ballot.

The ballot will be presented to the membership in May via email and written correspondence. Each general member and distinguished fellow is allowed to vote. We strongly encourage you to let us know of those members who you feel will make a real contribution to the future of our society and our profession. We will take your input seriously, and strive to present the best candidates possible. Thanks for pulling together to make our great society even greater.

The 2015 Nominating Committee
Chair: Marty Drell, MD, New Orleans, Louisiana
Carl Feinstein, MD, Palo Alto, California
Richard Martini, MD, Salt Lake City, Utah
Rachel Ritvo, MD, Washington, D.C.
Marianne Z. Wamboldt, MD, Aurora, Colorado

References
Join other AACAP members, and family and youth advocates, on April 23-24, 2015, to promote child and adolescent psychiatry and children’s mental health issues on Capitol Hill.

During this 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 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/LegislativeConference or contact Zach Kahan, Legislative Coordinator, @zkahan@aacap.org or 202-587-9669.
Infant Behaviors May Suggest Later Callous-unemotional Traits

Though the criteria for conduct disorder have long focused mostly on behaviors rather than actual traits a child might display, researchers have long focused on dysfunctional core processes of impaired emotion regulation, reduced responsiveness to others’ distress, and lack of guilt or empathy. The addition of the “with limited pro-social emotions” specifier in the DSM-5 grew out of this body of research on callous-unemotional traits to attempt to distinguish children who display traits that may be precursors of adult psychopathy from children who could be a developmental precursor to callous-unemotional traits in children.


Chemical in Broccoli Extract May Improve Some Core Symptoms in Autism Spectrum Disorder

Trying to summarize the biology of autism spectrum disorder (ASD), both in terms of what is known and unknown, is nearly impossible in a short space. On a cellular level, autism is associated with high oxidative stress and reduced antioxidant capacity, defects in glutathione synthesis, mitochondrial dysfunction, low oxidative phosphorylation, increased lipid peroxidation, and a variety of other processes associated with neuroinflammation. Researchers have also previously noticed that many children with autism and problematic behaviors actually have some lower preferential face tracking at five weeks scored higher on measures of callous-unemotional traits. Girls that were less sensitive to their mothers had higher callous-unemotional traits, but the effect did not show up for boys.

Much less clear is whether this reduction in looking at faces is a marker for later traits or whether the lack of social learning and development that results from less preference for faces may actually produce some of the callous-unemotional traits down the line. If the latter is true, there may be a role for developing interactions for infants that may increase either their preference for faces or times in which they have the opportunity to look at caregiver faces, hoping that these developmental pathways could be corrected in a way that might reduce callous-unemotional traits in children.

Chemical in Broccoli Sprouts May Improve Core Symptoms of Autism

Researchers gave 29 young men (aged 13-27) with moderate-to-severe ASD sulforaphane derived from broccoli sprout extracts and 15 men an indistinguishable placebo for 18 weeks. Each participant was evaluated using the Aberrant Behavior Checklist (ABC), Social Responsiveness Scale (SRS), and Clinical Global Impression Improvement Scale (CGI-I). Compared to those who received placebo, the participants receiving active treatment showed 34% improvement in the ABC and 17% improvement on the SRS. On the CGI-I, a significant number of participants had improvements in social interaction, abnormal behavior, and verbal communication. All of these improvements returned to near pretreatment levels upon discontinuation.

Whether or not larger scale research of this phytochemical demonstrates clinically significant improvements, treatments targeting cellular abnormalities associated with ASD in order to improve core symptoms (rather than just behaviors) likely represent the future of autism therapeutics, and the idea that a chemical in broccoli sprouts could be a developmental precursor to callous-unemotional traits may offer promise for addressing these impairments early in life.

relatively benign antioxidant could produce significant effects remains exciting.


Cyber Dating Abuse: A Risk Factor for Relationship Abuse in Real Life

More than three quarters of adolescents have a cell phone and more than 9 in 10 have their own computer. More than half exchange text messages daily and almost a third report daily communication through social networking sites. “Sexting” and “cyberbullying” are just a few of the terms that popular media has coined to try to capture some of the more harmful forms of communication that plugged-in youth face nowadays. Cyber dating abuse (CDA) is a somewhat broader term for unhealthy behaviors that have arisen in the face of near-constant connectivity. Examples of CDA may include trying to get someone to talk about or participate in unwelcome sexual activities, soliciting partners to share nude or seminude photographs, publicly posting or sharing personal photographs, constantly checking up on where a partner is or who the partner is with, and spreading rumors.

The current study in Pediatrics tries to estimate the prevalence of CDA and explore associations with other forms of relationship abuse and reproductive and sexual health indicators. A cross-sectional survey was conducted of 1,008 youth aged 14-17 years at school-based health centers. Over 40% of those surveyed had experienced CDA in the past three months, with female respondents (44.6%) being much more likely to report CDA than males (31.0%). About a third of girls were asked to send nude or seminude photographs, compared to about a sixth of boys. CDA was significantly associated with real life physical or sexual relationship abuse and non-partner sexual assault. Girls who had more CDA exposure were less likely to use contraception than girls with less CDA exposure.

The researchers conclude that the prevalence of CDA is fairly high in adolescents, and those who experience it are at much higher risks for a variety of negative outcomes. While the study does not explore the clinical utility of screening for CDA in the psychiatric setting, child psychiatrists may want to add questions about CDA to their assessment of risky behaviors and online behaviors to start discussions with youth about challenges they face that may otherwise go unnoticed in our clinical encounters.


Exercise May Be Good Medicine for Children with ADHD

Though stimulant medications and labor-intensive behavioral interventions demonstrate significant effects in children with attention-deficit/hyperactivity disorder (ADHD), many children with ADHD still have significant symptoms that are not well-targeted by the interventions, and not all children can tolerate medications or have access to behavioral interventions. Lifestyle interventions, regardless of other treatments, may provide unique opportunities to improve symptoms of ADHD. The idea that physical exercise may be helpful for kids with ADHD is appealing on many levels. Physical exercise is good for you anyway. There is a certain logic to hyperactive kids simply needing to burn off some of that energy so they can settle down. In addition, some prior research suggests that physical exercise may benefit cognitive function through improved oxygenation and blood flow in the brain, promote cerebral capillary growth, increase neurotransmitter levels, and promote release of neurotrophic factors.

Knowing this, researchers recruited a sample of 202 early elementary school students in kindergarten through second grade, 98 of whom were assessed as being “at risk” for ADHD and 108 children who were “typically developing” to serve as a control group. The children were randomly assigned to participate in a half-hour before school program of moderate-to-vigorous physical activity or a sedentary classroom-based intervention consisting of art projects. Both programs lasted for 12 weeks.

Parents of children in the physical exercise program noted significant improvements in moodiness, oppositionality, inattention, and hyperactivity. The improvement was greater in the ADHD-risk group. Both interventions appeared to improve symptoms for the ADHD-risk group, according to teachers. Peer functioning improved for both interventions, with greater effects in the ADHD-risk group.

To summarize, a before-school intervention of either physical activity or a sedentary art project seems to generally benefit inattentive and hyperactive symptoms for all children at school, though children who are at risk for ADHD symptoms seem to enjoy even greater benefits than typically developing children. The physical activity seems to benefit children at risk for ADHD both in the home and school settings.

Although the effects observed in the study were fairly modest, parents and schools looking to help children with ADHD settle down in the morning and beyond may look to adding physical activity to their morning routines.

Thank You for Participating in AACAP’s Educational Needs Assessment!

Thank you to over 1,400 members who participated in AACAP’s Educational Needs Assessment last July. The Task Force on Educational Infrastructure really appreciates your feedback and we want to update you and the rest of the membership on the results as we continue our charge to improve upon the ways that AACAP provides you with educational resources. I would also like to thank the other members of the Task Force for their work on this project: Anne Glowinski, MD, Tristan Gorrindo, MD, J. Michael Houston, MD, Howard Liu, MD, Neal Ryan, MD, and Heerain Shah, MD. The data from the survey are extremely comprehensive, and if you have comments or questions about these findings, please email me at gfritz@aacap.org.

30% of AACAP Members Don’t Use AACAP’s Educational Resources

Based on an overall response rate of 17.1%, we found that roughly 1/3 of AACAP members have not used any of AACAP’s educational resources in the last five years. The mean age of these members is 54.8 years; 57% are male, 43% female. Throughout the analysis of this data, we specifically examined this group to gain a better understanding of their needs so that AACAP can better serve them.

Members Generally Rate AACAP’s Current Educational Products Highly

As seen in the graph below, when asked about AACAP’s current offerings, AACAP members were largely satisfied, especially compared to similar offerings at other organizations. The Annual Meeting is the most highly rated product and also the most used.

Satisfied with quality of professional development by source

<table>
<thead>
<tr>
<th>AACAP Annual Meeting</th>
<th>4.57</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-person educational programs</td>
<td>4.44</td>
</tr>
<tr>
<td>Conferences &amp; in-person education</td>
<td>4.17</td>
</tr>
<tr>
<td>Non-CME Resources</td>
<td>3.77</td>
</tr>
<tr>
<td>Journal CME</td>
<td>4.10</td>
</tr>
<tr>
<td>Online CME</td>
<td>3.98</td>
</tr>
<tr>
<td>Maintenance of certification resources</td>
<td>4.10</td>
</tr>
</tbody>
</table>

1 = “Very Dissatisfied”   5 = “Very Satisfied”
Lecture is Still the Most Popular Way to Learn

The graph describes learning style preferences across the entire membership and it is clear that the lecture format continues to be the most popular expressed learning style. However, when analyzing these data generationally, it is clear that the younger members tend to prefer viewing content in a small group setting and with multimedia elements more than do older members. As the Task Force examines new program formats, we will try to provide an optimal combination of options to meet the needs of our diverse membership.

Choose the learning styles that most match your preferences

<table>
<thead>
<tr>
<th>Learning Style</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening to expert presenters give a lecture</td>
<td>81%</td>
</tr>
<tr>
<td>Reading professionally-developed resources on my own</td>
<td>74%</td>
</tr>
<tr>
<td>Viewing/listening to content with multimedia elements (video, graphics, and images)</td>
<td>64%</td>
</tr>
<tr>
<td>Exploring content in a small group setting</td>
<td>43%</td>
</tr>
<tr>
<td>Interacting with peers in the audience</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
</tr>
</tbody>
</table>

Members Are Generally Positive About Online Learning

As shown in the graph below, when asked about their thoughts on the positive elements of online learning, members were generally supportive of this mode of educational programming. Scheduling and lack of time for education were the biggest barriers to using educational products and thus an advantage for online learning. AACAP is considering expanding its online learning opportunities to meet these needs.

How positive are the following features of online learning?

<table>
<thead>
<tr>
<th>Feature</th>
<th>Very positive</th>
<th>Some positive</th>
<th>Neutral</th>
<th>Some negative</th>
<th>Very negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many on-demand programs allow me the flexibility to watch and learn on my schedule</td>
<td>54%</td>
<td>28%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of online learning is lower because of lower fees and no travel/housing costs</td>
<td>45%</td>
<td>31%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online learning gives me better access to regular presentations from high profile/high quality speakers</td>
<td>44%</td>
<td>31%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online presentations tend ot be more focused, without intervention from participants</td>
<td>28%</td>
<td>30%</td>
<td>31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other positive features</td>
<td>13%</td>
<td>8%</td>
<td>66%</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

You Spoke…We’re Listening

One of the most valuable questions in the survey addressed how AACAP can improve its educational products to meet your needs. It’s clear that all of these improvements would be highly valued, so we are now working to try to meet your needs in these areas and hope that we can provide some upgrades in the coming years, especially as it relates to search functionality of the website.

Rate value of potential benefits AACAP may consider

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Value highly</th>
<th>Value somewhat</th>
<th>Value slightly</th>
<th>Don’t value much</th>
<th>Don’t value at all</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Searchable access to a complete library of AACAP’s educational content from multiple sources</td>
<td>64%</td>
<td>21%</td>
<td>5%</td>
<td>8%</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Expanded opportunities for self-paced online education programs available on demand</td>
<td>54%</td>
<td>25%</td>
<td>8%</td>
<td>8%</td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>A more robust, formal learning experience online with high-quality AACAP educational resources</td>
<td>53%</td>
<td>24%</td>
<td>8%</td>
<td>8%</td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>Ability to track my CME hours and other educational requirements in one central system</td>
<td>45%</td>
<td>22%</td>
<td>8%</td>
<td>8%</td>
<td></td>
<td>12%</td>
</tr>
</tbody>
</table>
Want to change a child’s life?

Become a Hope Maker.

When you make a monthly donation to AACAP, you automatically join our new giving program.

Make a Donation. Give Hope. Make an Impact.

... for children with mental illness.

You can direct your Hope Maker donation to support:

- Medical Student Fellowships
- Research
- International
- and more!

To learn more and to join, please visit: www.aacap.org/hopemaker

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Media Page

Harmony Raylen Abejuela, MD, Resident Editor

Watts Meets a New Friend

By Gaston Blom, MD (aka “Grandpa Blom”) Illustrations by JD Deering

Larch Press, 2013
22 pages - $9.95 paperback

This is the most recent book in Dr. Blom’s series of children’s books about a boy named Henry, the central character, and his imaginary friend Watts, who lives in a light bulb. In his third book, Dr. Blom, fondly known as Grandpa Blom in this book series, addresses topics that children commonly encounter in school, such as meeting new people who may physically look different from them yet share common interests. Developing friendships is also explored. Most children share a fear of the dark: Through Henry’s imaginary friend Watts, that fear is also addressed. Vividly illustrated by JD Deering, Henry’s story and experiences come to life. Clinicians and other mental health providers may use this book with pediatric patients during their sessions. It may also be recommended to parents having had to deal with their child’s questions, fears, and concerns with meeting new people, while encouraging acceptance and appreciation of everyone’s similarities and differences.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Harmony Raylen Abejuela, MD, at harmonyraylen@hotmail.com.
AACAP Mentorship Network

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

The Mentorship Network aims to:

- Identify, recruit & provide quality mentors to medical students, residents & early career psychiatrists interested in child and adolescent psychiatry;
- Introduce mentors & mentees;
- Recruit medical students & residents into child and adolescent psychiatry; and
- Enhance careers & build relationships between mentors and mentees.

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

Contact:
AACAP Research, Training, and Education Department
(202) 966-7300 • training@aacap.org
AACAP Facts for Families

Not all children grow from infancy through their adolescent years without experiencing some bumps along the way. While every child is unique and special, sometimes they encounter emotions, feelings, or behaviors that cause problems in their lives and the lives of those around them. Families often worry when their child or teenager has difficulty coping with things, feels sad, can't sleep, gets involved with drugs, or can't get along with family or friends.

AACAP Facts for Families are fact sheets that provide concise and up-to-date information on issues that affect children, teenagers, and their families. AACAP currently has 115 fact sheets that are a great resource for doctors, patients, parents, schools, clinics - anyone!

Find AACAP Facts for Families online and in PDF format to download at www.aacap.org.

AACAP Resource Centers

AACAP Resource Centers empower consumers through patient education. Each AACAP Resource Center contains consumer-friendly definitions, answers to frequently asked questions, clinical resources, expert videos, and abstracts from the JAACAP, Scientific Proceedings, and Facts for Families relevant to each disorder.

Find AACAP Resource Centers online at www.aacap.org.
We once again thank Fred Seligman, MD, for acting as AACAP’s official photographer for the 2014 Annual Meeting.

Fred’s efforts are not only beautifully detailed, but they successfully capture the true spirit of AACAP!
61ST ANNUAL MEETING RECAP

Photo spread courtesy of Fred Seligman, MD
61ST ANNUAL MEETING RECAP

Photo spread courtesy of Fred Seligman, MD
The AALI program, created by AACAP’s Training and Education Committee, is a virtual teaching academy to engage members in exciting educational initiatives.

The goals of the AALI program:

- Serve AACAP in the development of innovative educational resources in partnership with its members;
- Ensure that the educational resources are made available to members at the annual meetings and on the web;
- Provide an inclusive community for all educators to allow for support, recognition, and innovation.

AALI is open to all AACAP members with an interest in education.

For more information or to be a part of AALI, contact training@aacap.org or (202) 587-9663.
Clinical Perspectives 42: Neuropsychopharmacological Nomenclature

Heather Joseph, DO

Current neuropsychopharmacological nomenclature dates back to the 1950s with terms such as antipsychotic and antidepressant that are based on their clinical use at that time. New scientific understanding of the transmitter target, mode of action, and use of these agents for expanded clinical use are not captured by traditional nomenclature. The current nomenclature can be confusing for patients regarding their diagnosis, can be stigmatizing, and does not aid in clinical decision-making. With these factors in mind, a neuropsychopharmacology nomenclature taskforce was developed consisting of representatives from the European College of Neuropsychopharmacology (ECNP), American College of Neuropsychopharmacology (ACNP), Collegium Internationale de Neuropsychopharmacology (CINP), Asia College of Neuropsychopharmacology (AsCPN), and in conjunction with the International Union of Basic and Clinical Pharmacology (IUPHAR).

Heather (Liebherr) Joseph, DO, presented the taskforce’s proposed multi-axial template to include four axes: Axis 1: Pharmacological Target and Mode of Action, Axis 2: Approved Indications by major regulatory bodies, Axis 3: Efficacy and Side Effects, and Axis 4: Neurobiology. During the 2014 ENCP meeting, a press conference was held introducing this proposed system and an app, Neuroscience Based Nomenclature (NBN), was released, which classifies 108 compounds under this new multi-axial system.

Graham J. Emslie, MD, presented on the antidepressant class of medications noting that these agents have indications outside the treatment of major depressive disorder. Some of the other indications include obsessive compulsive disorder (OCD), bulimia nervosa, panic disorder, seasonal affective disorder, generalized anxiety disorder, posttraumatic stress disorder (PTSD), bipolar depression, and neuropathic pain. For some “antidepressants,” the effect size is larger for the treatment of anxiety than it is for depression. In addition to being misleading, the term antidepressant can be stigmatizing, which can lead to poor compliance on behalf of patients. Pharmaceutical companies are aware of this stigma and have, at times, released a neuropsychiatric medication under a new name when marketed for alternative use. For example, bupropion is sold under the brand name Zyban for use in smoking cessation.

Adelaide S. Robb, MD, discussed challenges with the current nomenclature in regards to mood stabilizers. Pediatric neurologists classify anti-epileptic drugs by the electrolyte/ionic channels they regulate and their action at that channel. As research aims to identify underlying mechanisms for psychiatric illnesses and genetic variations of the same disorder, a clear understanding of the pharmacological actions could be helpful in tailoring medication management of the disorder.

Laurence L. Greenhill, MD, contrasted the nomenclature of stimulants, which implies therapeutic action, to that of alpha agonists, which refers to pharmacological action. He highlighted frequent confusion by patients and parents regarding the use of stimulants for a child with hyperactivity, noting that the name is paradoxical to the clinical indication. Under the newly proposed nomenclature, dextroamphetamine would be referred to as a dopamine multifunctional multimodal (DAmF-mM) agent, a dopamine and norepinephrine reuptake inhibitor and releaser. Although the new nomenclature is more descriptive of the action of the agent, it is not necessarily more clarifying for patients and families.

John T. Walkup, MD, began his presentation by highlighting the multiple uses of antipsychotic agents. He observed that the proposed nomenclature would provide a better understanding of the receptor profile, which could be helpful in selecting a first-line agent. For example, asenapine has strong D1 receptor action, which could be useful in the treatment of Tourette’s Disorder. Conversely, a nomenclature based on known pharmacological properties potentially gives “the illusion” that response to an agent is directly correlated to the neurotransmitter profile.

Dr. Walkup is hopeful that, as the RDoC aims to dismantle psychotic disorders into systems and symptoms, new indications will become the focus of pharmaceutical development, which will lead to more broad approval possibilities for children and adolescents. He postulated that development of pharmacological agents has not occurred for aggression, since aggression is a symptom and not a psychiatric disorder. Dr. Robb commented that this is unique to psychiatry, giving examples of extensive pharmaceutical developments for fever and pain, both symptoms of disorders.

In the closing remarks, Dr. Emslie stated that the neuroscience-based nomenclature proposed by the taskforce could be a good teaching tool for clinician education. However, he wonders if it should have less emphasis on Axis 2

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Symposium 1: Beyond the Prescription Pad: Psychotherapy Interventions for Youth With Severe Mental Illness

Mary S. Ahn, MD, Co-chair, AACAP Psychotherapy Committee

The AACAP Symposium Beyond the Prescription Pad: Psychotherapy Interventions for Youth With Severe Mental Illness (SMI) featured strategies for addressing common clinical conundrums often refractory to medication management alone. This symposium was co-sponsored by the Psychotherapy Committee and the Early Career Psychiatrist Committee. Symposium Chair Mary S. Ahn, MD, from the University of Massachusetts Medical School, provided an overview and discussed the current knowledge and practice gaps in our work with severe mental illness (SMI) youth.

With the continued and growing need for child and adolescent psychiatry services, innovative programs have changed the landscape of mental healthcare delivery. Primary care providers are becoming better equipped to handle less complicated cases; child psychiatrists are treating more youth with SMI in a variety of levels of care and in consultation (AACAP Taskforce on Healthcare Delivery Systems, 2013). There is evidence to support the use of psychotherapy interventions to enhance psychopharmacological treatments in youth with SMI. Despite the growing evidence, barriers continue to exist: lack of trained therapists (in a particular modality) in many communities, multi-complex families cannot see two practitioners for split treatment, and some patients/families are still pre-contemplative about engaging in therapy. We, as child and adolescent psychiatrists, are uniquely poised to deliver components of psychotherapy even in a consultative or brief psychopharmacology encounter. Furthermore, the presenting issues discussed in the symposium highlight how medication interventions alone have limited efficacy and/or do not address the issues of medication non-adherence and other factors that affect the youth or their families. All speakers were tasked with providing a brief overview of the evidence base in their mode of psychotherapy intervention, as well as pragmatic tools for attendees to use in their various practices. In addition, they presented resources so that attendees could seek out further knowledge and skills-training.

David J. Miklowitz, PhD, from UCLA Semel Institute presented “Mood Dysregulation and Psychosis: Family Focused Therapy.” Family-focused therapy (FFT) consists of 12-21 sessions over 4-9 months. The approach comprises: assessment and engagement with family, psychoeducation, communication enhancement training, and problem-solving skills training. Dr. Miklowitz shared data demonstrating how assessing families could help guide prognosis prior to treatment. He presented psychoeducational handouts that were created to help families recognize core symptoms of mania as well as core psychotic symptoms. In addition, he presented examples of how to create a relapse prevention plan collaboratively with both the youth and the family. Lastly, he discussed how to troubleshoot issues with medication adherence using FFT principles. In another handout, Dr. Miklowitz provided practical guidance to “active listening.”

Blaise Aguirre, MD, of Harvard Medical School, presented “Self-Injurious Behavior: Dialectical Behavioral Therapy” and discussed how dialectical behavioral therapy (DBT) is utilized in a continuum program for transitional age youth at McLean Hospital. In DBT, a key assumption is that self-destructive behaviors are learned coping techniques for unbearably intense emotions. Medications have limited efficacy in fully treating the underlying emotional suffering, dissociative symptoms, or the self-injurious behaviors. Although DBT has been studied and demonstrates efficacy in reducing self-injury, the target population has historically been limited to those with Borderline Personality Disorder (BPD). Self-injury, however, is not restricted to BPD and is a maladaptive coping strategy that is also found in other youth with SMI. Dr. Aguirre summarized the basic components of skills-training in DBT: mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. He led the attendees in a brief exercise using focused attention and breathing that a child and adolescent psychiatrist may use with his/her patients. In addition, he shared several tools, including one that identifies and rates various emotions, as well as worksheets that provide alternative coping strategies for youth to practice.

Victor Fornari, MD, from Hofstra North Shore LI School of Medicine on Long Island, presented “Maladaptive Eating Behaviors: Psychodynamically-Informed Therapy.” Dr. Fornari provided a comprehensive summary of the evidence to support psychotherapy in eating disorders. No particular intervention alone was considered to have strong supportive evidence. He also detailed the conundrum of research in psychotherapy, and how non-manualized treatments may be harder to control in a study. Next, he presented the case of a preadolescent girl with anorexia nervosa successfully treated with psychodynamic psychotherapy over a five-year period. Through his description of the process of therapy, he demonstrated how he built a relationship with a difficult-to-engage patient and her family. He described the particular clinical issues that made other evidence-based therapies of eating

continued on page 40
Beyond the Prescription Pad continued from page 39

disorders nearly impossible to implement. Dr. Fornari described a systematic approach “approximating manualization” to the psychodynamically-informed treatment by listing the progressive stages of treatment and the progressive developmental goals addressed.

Anne Bodmar Lutz, MD, of University of Massachusetts Medical School, presented “Substance Misuse: Solution-Focused Therapy.” Solution-focused therapy (SFT) is an evidence-based intervention for substance abuse, as supported by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-Based Programs and Practices based on numerous effectiveness studies. The core principle of SFT: “If it works, do more of it. If it doesn’t, do something different.” SFT assumes the following: 1) that solution behaviors already exist for patients (and their families) and can be discovered through the therapist’s interview, 2) solutions are not necessarily directly related to the presenting problem, and 3) small increments of change lead to larger ones. Dr. Lutz provided facilitative questions for discussion consistent with SFT including “What are your best hopes so that when you leave you can say it was helpful for you and worth your time?” Often, strength-based questions can help discover under-utilized resources that can be used to build skills to address substance misuse.

Dr. Lutz demonstrated components of SFT interviewing with video case examples. One example was how questions exploring the youth’s perspectives regarding important persons and relationships in his/her life can be used to help the youth build more effective solutions. Another example demonstrated the use of scaling questions to rate the goals, satisfaction, coping strategies, motivation for change, etc. These scaling questions can also be adapted and used to assess treatment response to a particular medication.

Attendees gained perspective on the considerable overlap (along with contrasts) across the various modalities of therapy. In order to provide further integration of principles of the various psychotherapies for SMI youth, Rachel Z. Ritvo, MD, of George Washington University School of Medicine and Health Sciences, facilitated a panel discussion with audience participation. A sample question was how one might have handled the difficult parent in the eating disorder case. All of the speakers approached the issue differently using the principles of their modality of psychotherapy.

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(disapproved indications by the Food and Drug Administration [FDA], etc.). There are fewer studies conducted in child and adolescent psychiatry, leading to a lack of FDA-approved medications for this population. On the other hand, Dr. Walkup commented that this shift in nomenclature might discourage pharmaceutical companies from seeking patent extensions for new indications.

Dr. Greenhill noted that in 2004 the FDA Black Box Warning for antidepressants regarding increased risk of suicide for children, adolescents, and young adults “tainted” 39 agents without studies on all agents within the class. This warning had a strong negative impact on the field of child and adolescent psychiatry.

The audience supported the belief that a move to a neuroscience-based approach to disorders (DSM-5) and neuropsychopharmacological nomenclature is valuable. They also felt that there is room for improvement in the proposed multi-axial template for nomenclature to include a developmental axis with long-term use outcomes and side effects. Additionally, they would like to see attention focused on ethnic and racial considerations, as well as notation of differences between disorders as they are seen in childhood compared to adulthood.

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Dr. Joseph is a PGY-4 child and adolescent psychiatry fellow and chief of the Psychiatry Research Pathway at Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center. She may be reached at liebherrh@upmc.edu.

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Honor Your Mentor in the March/April issue of AACAP News

In the March/April issue of AACAP News, you have the opportunity to honor your mentor(s). Whether you’re a medical student, resident, active researcher, or practitioner, or retired—someone made a significant impact on your career.

We’re asking all of you to take the time to honor your mentor and tell others why they were important to you, and how they influenced your life.

In 100 words or less, tell us who served as your mentor. E-mail submissions to communications@aacap.org by February 1, 2015. Please include your name, affiliation (if appropriate), the name of your mentor(s), and a short testimonial or anecdote. If possible, a picture would be a great addition to your testimonial!
And They Pay You For That? James P. Comer, MD’s “Common Sense” Odyssey in the Schools

James P. Comer, MD, is the 2014 recipient of the 2014 AACAP’s Sidney Berman Award for the School-Based Study and Treatment of Learning Disorders and Mental Illness.

Toward the end of Maggie Comer’s life, when her eldest son James stopped by to visit her in the home where he grew up, she asked him, “By the way, son, what exactly do you do for a living anyway?” After giving her a detailed description of his work in the schools, she responded, “Why that’s just common sense… and they pay you for that?” Looks like James’ upbringing in East Indiana by his hard-working common sense parents, Maggie and Hugh Comer, paid off. They stressed the importance of a good education coupled with core values: respect, honesty, patience, scholarship, humility, punctuality, and perseverance. Collectively, James and his four siblings garnered 13 academic degrees, an incredible accomplishment in any family.

Fast forward to 1968 when Al Solnit, MD, director of Yale School of Medicine’s Child Study Center, dispatched his newly hatched child psychiatrist, Dr. Comer and Dr. Comer’s entourage to work collaboratively in two of the worst elementary schools in New Haven, Connecticut. He had no idea what to expect. Understandably, Dr. Solnit probably suspected that Dr. Comer and his team would return after a few frustrating months dejected, and crying “Foul!”, “Impossible!”, or worse, “WE QUIT!” Rather than demoralized and worn out, Dr. Comer returned after five years like an “Energizer Bunny,” ready to take on the entire United States educational system. During this time, he and his team managed to develop a comprehensive “common sense” and effective School Development Program (SDP). Most importantly, they had helped these two low achieving schools to rise miraculously, like a Phoenix, to among the highest performing in their district on every measure. An astounded Dr. Solnit began to fully appreciate what Maggie and Hugh Comer’s eldest son was made of.

Dr. Comer’s success launched his lifetime career working in schools to better the lot of children. He and his team established the SDP as an integral school operating system, NOT a supplemental nice-to-have add-on. It focused on each student’s healthy development and optimal learning. The developmental dimensions included six essential pathways: socio-interactive, psycho-emotional, ethical, linguistic, and physical. To accomplish these lofty goals, the SDP mandates the creation of an appropriate supportive school milieu in which all stakeholders work together toward a common goal. These stakeholders include: principal, school support, and administrative staff, teachers, parents, professionals, school district and community leaders, and last but not least, students. Through team building processes, these stakeholders learn to hone in on effective acceptable solutions that ultimately serve the best interests of their students who are part of the process. This collective stakeholders’ buy-in also insures the longevity of their specific SDP.

Over the past 45 years, Dr. Comer and his team have successfully implemented the SDP in more than 400 schools in 35 school districts, from K thru 12, for students across the socioeconomic spectrum to support positive development in all young people. When students evolve developmentally at home and school, they are most likely to reach their full potential. In referring to Dr. Comer’s SDP, Professor David Reynolds of England’s Plymouth University and founder of the International Congress for School Effectiveness and Improvement (ICSEI) posited that “his [Comer’s] approach, because of its emphasis on the social and the community, as well as the academic, is one, maybe even the only one that can save public education around the world.” If Maggie Comer were alive today, she would have undoubtedly proudly exclaimed: “That’s my boy!!”

Dr. McCarthy has been a member of AACAP’s Schools Committee since 2002. He is a retired associate clinical professor of Child and Adolescent Psychiatry of the New York University School of Medicine’s Child Study Center where he ran the School-Based Mental Health for the child psychiatry fellows and directed the Consultation-Liaison Program.
Irritability is a common concern for youth presenting for mental health services, and severe anger outbursts are a frequent precipitant for inpatient psychiatric hospitalization. Concerns that children and adolescents with chronic, severe irritability were being inappropriately diagnosed with bipolar disorder prompted the DSM-5 to create a new diagnosis: Disruptive Mood Dysregulation Disorder (DMDD). The core criteria for DMDD are recurrent, severe temper outburst (≥ 3 per week) and irritable/angry mood most of the time, for at least 12 months duration. However, little data exists regarding this new diagnosis, and most of the applicable research is pertained to Severe Mood Disregulation (SMD) syndrome, which is a related construct. The symposium organized by Lea Rose Dougherty, PhD, and colleagues provided new information regarding DMDD, irritability and affective dysregulation.

Dr. Dougherty started the symposium by presenting data from the Stony Brook Temperament Study, which is a large community-based study of 541 children followed from ages 3 to 9. At age six, 8.2% of participants met criteria for DMDD. Participants with DMDD also met criteria for another disorder 60.5% of the time. Diagnostic overlap with SMD was moderate, as 47% of the participants with DMDD meeting criteria for SMD and 58% of those with SMD meeting criteria for DMDD. DMDD at age six was associated with parental lifetime diagnosis of substance use disorder and higher maternal-rated child surgery at age three. Surgency is a trait that combines aspects of positive affect, impulsivity, and tendency to approach environmental stimuli. A DMDD diagnosis at age six was associated with a diagnosis of oppositional defiant disorder (ODD) and ADHD at age nine, but not depression or anxiety disorders. DMDD at age six was also associated with higher levels of impairment, rates of outpatient treatment, and psychotropic medication use at age nine.

Dr. Dougherty also examined chronic irritability as a dimensional measure and looked at severity of irritability at age three and outcomes at age six and nine. Irritability at age three was associated with a diagnosis of depression and ODD at age six, as well as greater functional impairment. Preschool irritability was also associated with anxiety disorders, greater functional impairment, and higher rates of treatment at age nine. A family history of depression and anxiety disorder was associated with irritability at age three. In summary, Dr. Dougherty showed that chronic irritability, whether measured dimensionally in preschool or as the categorical diagnosis of DMDD at age six, was associated with adverse outcomes later in childhood.

Sara J. Bufferd, PhD, also presented results from the Stony Brook Temperament Study, but focused on affective dysregulation at age three predicting psychopathology at age six. She examined the Dysregulation Profile derived from the Child Behavior Checklist (CBCL-DP). The CBCL-DP combines the T-scores from the attention, aggressive behavior, and anxious/depressed subscales of the CBCL and is positive at scores ≥ 180. Though the CBCL-DP has been shown to be associated with a diagnosis of bipolar disorder in youth, it is also associated with many other diagnoses and outcomes so that it is not a specific marker of bipolarity. At age three, 11.1% of the sample was rated CBCL-DP positive by mother-report and 6.4% by father-report. Dr. Bufferd found that mother-reported CBCL-DP at age three was associated with higher levels of impairment and diagnoses of ADHD, ODD, depression, and anxiety disorders at age six. It was also associated with teacher-rated psychopathology at age six, including problems with affect, ADHD, ODD, and social competence. Father-rated CBCL-DP at age three was associated with impairment and a diagnosis of ADHD and ODD at age six, but not any teacher-rated outcomes. Overall, the results demonstrated that affective and behavior dysregulation in the preschool years are associated with emotional and behavior problems later in childhood.

Chronic irritability in youth has not been shown to be associated with bipolar disorder in community studies. However, the low rates of bipolar disorder in these samples limit the power to detect associations. David Axelson, MD, examined DMDD and irritability in the Pittsburgh Bipolar Offspring Study, which is a longitudinal high-risk study of offspring of parents with bipolar disorder and offspring of community control parents. DMDD was much more prevalent in the high-risk offspring compared to the community controls (9.1% vs. 1.2%). Moreover, a preceding diagnosis of DMDD was associated with subsequent onset of mania or hypomania in the high-risk offspring. Subthreshold (hypo) manic episodes and DMDD were the only significant diagnostic predictors of future-onset bipolar disorder. Dr. Axelson also looked at parent-rated and child-rated severity of irritability in the offspring as a dimensional measure. Both parent-rated and child-rated irritability was significantly higher in the high-risk offspring compared to the community controls. Increased irritability was associated with future onset of mania or hypomania in the high-risk offspring. These results indicate that DMDD and irritability may be a risk factor for the development of bipolar disorder in the offspring of parents with bipolar disorder.

Jillian Lee Wiggins, PhD, presented data on dimensionally-rated irritability and maternal depression in the Fragile Families and Child Well-being Study, a very large population-based study of
children followed from birth to age nine. A measure of irritability intensity was derived from CBCL data at ages three, five, and nine years. Using latent class analysis, Dr. Wiggins and colleagues were able to identify five separate developmental trajectories of irritability. Most (61%) of the sample started with low intensity of irritability at age three, which decreased to very low intensity over time. About 21% started with moderate irritability that remained stable over time. Three-year-olds with high ratings of irritability had three trajectory classes: a class that stayed high, a class that decreased to low irritability, and a class that increased to very high levels. Recurrent maternal depression was associated with the high irritability classes at age three, particularly the class that progressed to very high irritability at age nine. Using cross-lag models, Dr. Wiggins showed that maternal depression predicted intensity of irritability in the children, but conversely irritability in the child was associated with depression in the mother. These results highlight the bidirectional context of maternal-child affective problems.

Gabrielle A. Carlson, MD, was the symposium discussant and put the presentations in context of her clinical sample of 361 youth, of which 12% met criteria for DMDD. In the clinical sample, youth with DMDD were much more likely than non-DMDD youth to meet the CBCL-DP profile, though they did not differ on teacher-reported variables. The DMDD clinical subjects were more likely to have a family history of anxiety, depression, mood swings, tics, and suicide. Dr. Carlson then led arousing discussion that focused on some of the controversies surrounding the diagnosis of bipolar disorder and DMDD in youth.

Dr. Axelson is the chief of Child and Adolescent Psychiatry and medical director of Behavioral Health at Nationwide Children’s Hospital in Columbus Ohio, and is a professor of Psychiatry and chief of Child and Adolescent Psychiatry at The Ohio State University College of Medicine. He may be reached at David.Axelson@nationsidechildrens.org.

Previews From the Pipeline 2014: A Data Blitz Featuring Early Career Investigators

Tamara Vanderwal, MD, and Thomas V. Fernandez, MD

Many early career researchers in the field of child and adolescent psychiatry present data at other important conferences, including the American College of Neuropsychopharmacology (ACNP), Human Brain Mapping, the International Meeting for Autism Research (IMFAR), and others. At most of these conferences, we are “the child psychiatrist doing neuroimaging” or “the child psychiatrist doing genetics research.” Presentations at these other conferences have to bridge the gap between audiences who generally are not familiar with key issues pertinent to child and adolescent psychiatry. Presenting our research to child and adolescent psychiatrists changes the dynamic, facilitating a different level of interaction and bringing together a mixture of approaches and disorders that would not otherwise be combined in a single conference session. “Previews From the Pipeline” was created three years ago to enable early career child and adolescent psychiatric researchers to interact with each other and with others who care about and understand their work in a unique way.

At AACAP’s 61st Annual Meeting, the third annual Data Blitz took place. This year’s Blitz followed the same fast-paced format as in years past: eight presenters each had seven minutes to present their work, followed by three minutes of question-and-answer. A panel of five expert clinicians and researchers (Barbara J. Coffey, MD, MS, Jean A. Frazier, MD, Joan L. Luby, MD, James J. McGough, MD, and Bradley L. Petersen, MD) provided most of the questions and comments. Audience’s questions were submitted to the panel throughout the session via an online chat room. This regimented format resulted in a ninety-minute data blitz that showcased the wide variety and high-caliber of new research by early career investigators in child and adolescent psychiatry.

Presenters in the Blitz were selected by the organizers based on the quality and relevance of their data. The co-chairs also aimed to assemble a diverse roster of speakers to cover a variety of topics and research modalities, as well as a full spectrum of early career stages and geography.

This year’s blitz was structured into three sections. The first two speakers focused on the use of neuroimaging to investigate cross-over symptoms between attention and anxiety. Jeffrey R. Strawn, MD, an assistant professor at the University of Cincinnati, presented on the neural correlates of anxiety in subjects with ADHD. Chad Sylvester, MD, PhD, an instructor at Washington University in St. Louis, presented imaging data on attentional circuitry in subjects with anxiety.

The next section highlighted research in three major clinical diagnoses, namely psychosis, obsessive compulsive disorder (OCD), and autism. Michael L. Birnbaum, MD, an assistant professor at Hofstra North...
Shore in New York presented a new data set on Internet use in adolescents and young adults who had recently developed psychotic symptoms. This descriptive data indicates that individuals suffering from new-onset psychiatric symptoms actively look for help on the Internet. Next up, Kyle Williams, MD, PhD, an instructor in psychiatry at Harvard, presented retrospective data from electronic medical records that suggest an association between OCD and IgA and IgM deficiencies. Natasha Marrus, MD, PhD, a postdoc/instructor at Washington University presented next. Her research focuses on a specific subset of social cognition called social motivation, which she studies in the context of reciprocal social behavior in toddlers. Dr. Marrus hypothesizes that social motivation could provide an early endophenotype for individuals with autism.

The final section of the blitz was comprised of work developing new methods within child and adolescent psychiatric research, covering such topics as voles, movies, and pylons. To begin this section, Devanand Manoli, MD, PhD, a postdoc at University of California San Francisco, presented his work on social attachment in voles. He described his work-to-date that attempts to genetically manipulate specific receptors in voles to provide an animal model for studying social attachment. Tamara Vanderwal, MD, an associate research scientist at Yale, presented next on her work using movies as fMRI stimuli with young children. Finally, Homero David Sandoval, MD, from the Children’s Psychiatric Hospital in Mexico City, presented a novel ecological approach to quantifying the effect of stimulant medications in children. His method is based on searching behaviors, and uses a simple set up of a grid of pylons in a field with balls hidden under each pylon. Children are instructed to retrieve all of the balls in the grid, and the effects of stimulant treatment are evident in a decreased number of errors made during the task.

The session was concluded by co-organizer Thomas V. Fernandez, MD, assistant professor at Yale, who reviewed twenty years of statistics from the National Institutes of Health (NIH) Office of Extramural Affairs. A startling and steady trend from 1980 through 2010 shows that R01 research grants (generally considered to be the hallmark of an independent research career) are being awarded by the NIH later and later in life, and a worrisome gap has opened up between the mean age of faculty appointment and R01 funding. The Data Blitz at the AACAP Annual Meeting is intended, in part, to help early career investigators connect with their own field and establish a useful research identity early in their careers so that they may better navigate, and perhaps alter, these trends.

Dr. Vanderwal is an instructor at the Yale Child Study Center. She may be reached at tamara.vanderwal@yale.edu.

Dr. Fernandez is assistant professor at the Yale Child Study Center and Department of Psychiatry. He may be reached at thomas.fernandez@yale.edu.

Both are graduates of the Albert J. Solnit Integrated Training Program at the Yale Child Study Center.
Member Forum: Crisis in the Emergency Department

Jennifer Havens, MD, and Warren Ng, MD, discussed the development of the nation’s first Child Comprehensive Psychiatric Emergency Program (C-CPEP) at New York’s Columbia University (since closed and now existing at Bellevue Hospital). They reviewed the program details and its positive impact on reducing admission rates to the inpatient units as well as wait times in the general emergency department. Dr. Havens is an advocate of approaching psychiatric care in the same way trauma care has developed over the past 30 years. She proposes a designation of “level I” or tertiary care medical centers with specialized psychiatric emergency facilities and teams created for stabilization. These designated hospital services would be designed to evaluate and stabilize children over a period of days to allow for disposition with close follow-up, or if need be, admission for inpatient care. Models such as the C-CPEP could help children avoid lengthy inpatient admissions, or boarding for days in an emergency department bay within a hospital that wasn’t designed for high-level psychiatric care.

Jeff Vanderploeg, PhD, presented Connecticut’s impressive Emergency Mobile Psychiatric Service Crisis Intervention Service (EMPS)–a 14-site program servicing the entire state. This mobile crisis service has an average response time of 28 minutes and has demonstrated significant improvement post-engagement in functioning and behavioral outcomes in youth. The program is funded through the Department of Children and Families and is free to any child under the age of 18 residing in Connecticut. There is no limit as to how many times families re-engage EMPS, which includes a multi-provider team and a variety of modalities that continues to treat patients after the initial crisis call is placed. Families, schools, physicians, and emergency departments can initiate a call to this service.

In Canada, Mario Capelli, PhD, directs the Mental Health Research Program at the Children’s Hospital of Eastern Ontario and spoke of his team’s development of the HEADS-ED rapid screening tool. This screen allows emergency department physicians to begin to classify and determine the risk and needs of a child presenting in psychiatric crisis. The aspects of the screen include questions about the patient’s home life, education and activities; and peers.

At AACAP’s 61st Annual Meeting, ten experts from around the country gathered for a Member Forum to discuss this crisis and to highlight innovative programs developed to face this challenge.

The forum opened with an overview from Jeffrey Bridge, PhD, associate professor of Pediatrics at Ohio State University. Dr. Bridge described current research findings that support what many have long suspected: children in psychiatric crisis are treated inconsistently and often by inadequately trained teams. Numerous factors affect overcrowding in the ED, including bed availability, insurance authorization delays, and lengthy evaluations. These departments are rarely designed with youth in mind, frequently holding adults, intoxicated individuals, and children together in neighboring bays. The majority of EDs are staffed by adult emergency medicine physicians with no psychiatry support. Disposition recommendations are infrequently documented and many children presenting with a post-suicide attempt are discharged from EDs without a mental health evaluation.

Stephanie Hartselle, MD

Very day, emergency departments (EDs) around the country are seeing more and more children in psychiatric crisis. In an article in 2007, AACAP member, Brady Case, MD, and his colleagues found that during the 1990s and 2000s, the rates of ED visits for pediatric mental health rose dramatically while the duration of inpatient stays were cut by almost half. Bed availability, provider shortages, and evaluation times all contribute to the rising rates of children spending hours or even days in emergency departments, awaiting appropriate care.

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Crisis in the Emergency Department continued from page 45

Drugs and alcohol, suicidality, emotions/thought disturbance, and discharge resources. Dr. Capelli had previously studied the documentation of ED providers related to mental health visits in children and found it to be notably lacking. This tool provides physicians with a consistent screen with which to approach all pediatric patients in the ED.

Discussants for the Member Forum also included Thomas Chun, MD, MPH, a pediatrician, child and adolescent, and adult psychiatrist who is an associate professor at Brown University and a pediatric emergency medicine physician at Hasbro Children’s Hospital. His work with the Pediatric Emergency Care Applied Research Network underscores his concern with improving standards of care for children in psychiatric crisis. He urged AACAP members to continue to pursue collaboration with our pediatrics colleagues, noting that our child health advocate voice is strongest when we work together at both the clinical and the legislative levels.

Finally, Brian Shuy and Michael Linskey from the AACAP Office of Government Affairs and Clinical Practice were on the panel to talk about AACAP’s efforts in Washington, D.C., to create awareness about this national crisis and to advocate for improving services and standards.

The audience represented AACAP members from across the country, concerned with the trend of escalating volume, length of stays, and contracting services for children and adolescents experiencing psychiatric emergencies. Consensus around standards of practice, the training of appropriate psychiatric teams, enabling standardized screenings, and improving the ED experience for patients and families were all raised as potential areas for continued improvement.

For those AACAP members involved in or concerned about these issues in their local area, there is a new Emergency Child Psychiatry Listserv available. To be added, please contact Dr. Stephanie Hartselle at stephaniehartsellemd@gmail.com.

Dr. Hartselle is a clinical assistant professor of Child and Adolescent Psychiatry at Brown University in Providence, Rhode Island, and is the chair of the sub-committee for Emergency Child Psychiatry. She can be reached at stephanie-hartsellemd@gmail.com.

AACAP’s Newest Lifelong Learning Module is Available

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Lawrence A. Stone, MD Plenary Summary

On October 25, 2014, John Fayyad, MD, associate professor of Clinical Psychiatry at the University of Balamand in El-Koura, Lebanon presented the Lawrence A. Stone, MD Plenary: “Conducting Research and Interventions for Children in Developing Countries: Challenges and Opportunities.” This is a summary of his presentation.

Dr. Fayyad highlighted the difficulties facing children in many developing countries, where strife, war, and conflict are all too common. His research on wars in Lebanon has shown that war increases the risk for childhood mental illnesses such as posttraumatic stress disorder (PTSD). However, war itself is not the only factor: the stability of the home and family environment is key for these youth. When home stability and support are failing, and other childhood adversities are present, youth become particularly vulnerable to the effects of war. In its wake, they are likely to develop depression, anxiety disorders, and PTSD.

Despite the enormity of the problem, there has been little research examining interventions that may help youth in developing countries to cope and recover from war. Along these lines, Dr. Fayyad has been examining ways to help war-afflicted youth using universal interventions. He argued that a universal intervention approach might be the first important step in helping children cope during and after war, while avoiding many of the costs of mass screening. Referral of more severe cases of mental illness would still serve as an additional level of intervention, but the hope would be to decrease the incidence of war-related mental illness more generally in youth early on.

Dr. Fayyad gave examples of interventions that his team has tried in Syrian refugee families in Lebanon. In a school-based intervention, his team trained teachers to become resilience coaches. This was not without cultural and political barriers, sparked in part by mistrust of European Union funding for the project. Dr. Fayyad’s team was able to overcome these barriers, and found that youth recipients of these interventions improved overall on internalizing and externalizing symptoms. Youth who particularly benefitted were those with low resilience scores or high anxiety scores, whereas youth with high depression scores actually worsened. This highlights the challenges of a universal intervention, and the need to tailor it to subgroups based on these data.

In a parent-based intervention, Dr. Fayyad’s team has been conducting a trial of parent-management training for Syrian refugee families. So far, nearly 500 women have participated, involving over 3,000 children from grades 4-7. Results from this intervention are pending.

“So what are the ‘Grand Challenges’ facing us in helping war-afflicted youth?” Dr. Fayyad asked. He noted that repeated media exposure to war incidents, family overcrowding, absent or disorganized governmental or non-governmental organization (NGO) responses, and fragmented mental and behavioral health services, all as major barriers to successfully helping these youth. Dr. Fayyad also noted the absence of organized child and adolescent psychiatry in Lebanon, lack of funding for interventions, and lack of personnel qualified to lead and conduct these interventions.

In the midst of such strife and chaos lie important opportunities, Dr. Fayyad argued. Such opportunities include the chance to test new universal interventions that can be integrated into real-life situations, which can do so at a relatively low cost and can begin to incorporate biological measures in studying interventions, such as genetic analyses. Yet, ultimately none of these interventions will benefit war-afflicted youth without enough mental health care providers. To this end, Dr. Fayyad stressed the importance of training permanent lay members of the community, such as mothers, nurses, and teachers. After all, these are the adults who touch these children’s lives every day. And if we can strengthen the healing power of that touch, perhaps more of these traumatized youth will emerge from their horrifying experiences to lead healthy, productive, and even happy lives.

Ryan Herringa, MD, PhD

Dr. Herringa is assistant professor of Psychiatry at the University of Wisconsin School of Medicine and Public Health. His research explores the neurobiological impact of pediatric trauma and PTSD. He may be reached at herring@wisc.edu.
61ST ANNUAL MEETING RECAP

Research Forum: The Use of Research Domain Criteria (RDoC) for the Study of Childhood Psychopathology

Stacy S. Drury, MD, PhD, and Bradley S. Peterson, MD

The unveiling of the Research Domain Criteria (RDoC) in April 2013, weeks before the release of the controversy laden DSM-5, triggered a lively debate for both clinicians and researchers. The challenges and promise of RDoC continue to be widely debated. While the majority of the debate has fallen in the arena of adult psychiatry, RDoC has substantial relevance for children too. The incorporation of a developmental perspective and the concerns related to how best to validate constructs whose measurement and underlying neurobiological mechanisms putatively change across the life course represent additional areas of concern for child psychiatry. Further, while RDoC is at first glance solely a research tool, the long-term clinical implications, should psychopathology indeed be reclassified, are significant. As a step toward enhancing dialogue between the National Institute of Mental Health (NIMH) and clinicians, AACAP’s 2014 Research Forum brought together speakers from diverse scientific backgrounds who hold a wide range of perspectives about RDoC. The goal of this day-long program was to create an interactive, bi-directional conversation to increase the understanding about RDoC, identify current challenges and criticisms of RDoC from the perspective of researchers, and establish next steps as RDoC evolves.

Bruce Cuthbert, PhD, director of the NIMH Division of Translational Research and Treatment Development, opened the symposium by presenting a brief historical perspective of events occurring in the six years since inception of the RDoC project. He noted the complimentary approach of RDoC and DSM-5, with both focused on the primary mission of NIMH: improving the diagnosis, treatment, and health trajectory of those with mental illness. Strikingly, while morbidity and mortality from many other medical illnesses has declined steadily over the last two decades, this has not been the case for psychiatric illnesses. In fact, suicide rates have remained static for the last three decades. Against this backdrop of outcomes data, RDoC was designed to be “a clean slate” upon which researchers can design novel studies and drive innovative advances in a field that is otherwise, unfortunately, static. Disorder-based diagnoses (DSM) have not yielded the desired advances in prevention and treatment, and DSM was developed for reliability at the expense of validity. Moreover, problems with disorder-based classifications are compounded by comorbidity, and heterogeneity. RDoC relies on translational neuroscience research showing that discrete neural systems support discrete behaviors and that those behaviors can be measured to study illnesses in a more valid way that will lead to more meaningful treatment advances than the DSM-based diagnoses.

Before the release of RDoC, a series of workshops by experts across multiple disciplines was charged with identifying the beginning framework for RDoC. The constructs proposed as the initial scaffold of the RDoC matrix were expected to: span diagnoses; specify a full range of variation; integrate neurobiology, genetics, behavior, and environmental and experiential aspects; and be amenable to the development of reliable and valid measures of these fundamental components. To date, RDoC has been incorporated explicitly into more than 40 grants, including 14 specific to child and adolescent psychiatry (CAP). Dr. Cuthbert cautioned that RDoC was designed as a beginning framework, and not a finished product. He also noted that while the long-term goal of RDoC is improved therapeutics through enhanced diagnostics, this was still a future goal. Importantly he noted that, particularly for child and adolescent psychiatry, RDoC was conceived as a method of providing a new level of freedom to researchers, allowing them to ask novel questions without being chained to DSM diagnoses, while encouraging developmental and environmental factors to be included. Intricately linked to this novel opportunity for researchers was the importance of incorporating both DSM-5 and RDoC into current training efforts. Dr. Cuthbert concluded with a discussion of the new initiatives within RDoC, including the upcoming release of a clinical trials program and the RDoC Unit (www.nimh.nih.gov/news/science-news/2014/nimh-creates-new-unit-to-support-its-research-domain-criteria-initiative.shtml), a new internal initiative to enhance education, collaboration, and research progress related to RDoC.

Dr. Adele Diamond, FRCP, FRCPsych, a psychologist from University of British Columbia, presented a discussion of the role of development in cognitive processes and the importance of expected normative differences in cognitive abilities when applying an RDoC approach. She discussed the challenges facing the RDoC matrix for some neurodevelopmental measures. In measuring inhibitory control, for example, the “cut” point between health and psychopathology is not clear and likely shifts across the course of development. Therefore, defining what reaches the level of psychopathology when using these more neurobiological constructs represents a challenge for clinical utility. She also noted that while measuring a construct
across development, e.g., inhibitory control, would in theory be expected to be useful, the underlying neural systems controlling it may actually change across development. Dr. Diamond also directly addressed concerns that the current measures of attention within the RDoC matrix do not adequately reflect the complexity of attention. She further noted the substantial overlap between some of the constructs selected, suggesting that at first attempt within the cognitive domain, distinctions are artificial and perhaps somewhat inaccurate, particularly in relationship to working memory, effortful control, and updating and active maintenance of memory. She then discussed the challenges of defining these constructs when considering stress, sex differences, and genetic variation. Thus, RDoC is clearly not a “one size fits all” solution.

David Shaffer, MD, took the perspective of a clinical consumer of RDoC. He discussed the historical and current concerns related to DSM-5, suggesting a conflict between classification systems that are intended to be descriptive compared to hypothesis generating. He noted that, through time, psychiatric diagnoses began to define an individual and suggested that this has contributed to the continued stigmatization of mental illness. He noted that changes in nosology have generally followed discoveries, and not led to them; and that RDoC will lead to new discoveries, something critically needed in child and adolescent psychiatry. As an example of the need to rethink current nosology, Dr. Shaffer discussed suicide. He noted that the developmental and neurocognitive aspects of suicide (e.g., planning and determining consequence of suicidal act) are understudied and likely would provide much needed insights that will drive improvements in prevention efforts.

Bradley S. Peterson, MD, questioned the current NIMH emphasis on RDoC for funding applications, suggesting that data on the reliability and validity of some of the RDoC measures is lacking, particularly as they pertain to human illnesses, and that requiring the widespread implementation of RDoC measures may be premature. Taking the RDoC construct of threat and other negatively-valenced items, he used the model of the “affective circumplex,” which posits that all affective states arise from the cognitive interpretation of core neural sensation, to argue that these constructs typically confound arousal with valence, which within the framework of the affective circumplex are independent and orthogonal neurophysiological systems. He also presented an array of intriguing and novel MRI findings showing that anatomical MRI scans can be used to construct computer algorithms that are entirely automated and that can classify with DSM diagnoses the brains from single individuals, and with very high specificities and sensitivities. His data suggest that this computational modeling approach is robust with respect to age, disease state, medication use, and comorbidity. Because anatomical features of the brain clearly mapped onto DSM diagnoses with great accuracy, these findings, and similar findings from other labs, provide considerable support for the neurobiological validity of DSM diagnoses, at least in terms of the biological family resemblance within broad diagnostic classes. These automated algorithms also offer promise for identifying biological subtypes within DSM disease categories. Development of novel and robust measurements for psychopathology, that are sensitive to development and treatment, represents a much needed direction for research.

Providing a perspective from pediatric pharmacology, Stephen P. Spielberg, MD, PhD, discussed the parallels of the challenges of RDoC and diagnostic classification with many other areas of medicine. He noted that the challenges within child and adolescent psychiatry are not unique among medical fields, and that all medical specialties are returning to basic biology to refine diagnoses and treatment. He cautioned that a failure of child and adolescent psychiatry to embrace a more nuanced biological model focused on understanding pathophysiology will likely substantially impair progress in the field. He noted that this was a unique challenge for psychiatry: if there are inadequate phenotypic descriptions that are validated with biomarkers applicable to clinical trials, then advances in clinical trials will be hindered. He encouraged child and adolescent psychiatry to partner more effectively with advocacy groups to drive the development of patient relevant outcomes and novel treatments. Using the example of cystic fibrosis, he noted that new treatments that targeted the genetic defect specifically, substantially improved outcomes and have the potential even to reverse the disease; however, the utility of these treatments was specific to a particular genetic mutation. Had researchers not carefully selected the patient population by their genetic mutation, the powerful treatment effects would have been missed. Child and adolescent psychiatry would also benefit from mapping treatments to specific causal pathways in pathogenesis.

The final presenter was Daniel Pine, MD, chief of the Section on Development and Affective Neuroscience in the NIMH Intramural Research Program. Dr. Pine reiterated the complementary, not competitive, nature of RDoC and DSM, and said that both approaches to classification and measurement have strengths and weaknesses. He also noted that while RDoC has significant potential to advance the field, the true impact of RDoC within the clinical realm is likely many years away. He also highlighted that although specific narrow behaviors are feasible to study from a multi-system approach, other behaviors, such as language, are not as amenable to an RDoC approach because they lack obvious methods of study in animal systems. Using attention bias to threat as a construct to study anxiety, he highlighted the critical developmental differences in relation to attention bias to threat and the liability for anxiety disorders. He noted that variability exists even within this narrow construct, depending on the context in which attention is measured. He then presented treatment data using attention retraining therapy and discussed the need to carefully select the participants for these kinds of studies as the impact of attentional retraining would differ should the individuals receiving the therapy have baseline neurobiological differences not adequately reflected in current DSM nosology. He noted that the need for careful charting of the neural circuits to behavior and their clinical interaction when approaching novel study design from an RDoC perspective.

continued on page 50
The Use of Research Domain Criteria (RDoC) continued from page 49

An interactive panel discussion focused on audience participation focused on the following areas: 1) The challenge of designing research studies to fit within the RDoC matrix and the long-term clinical applicability of RDoC. 2) RDoC fails adequately to incorporate the fundamental theories and data upon which the field has been built, and it does not adequately capture the true nature of psychological disorders and the large impact of experience and developmental changes. 3) Gaps in both DSM and RDoC around sex differences and sensitive periods, such as puberty, were noted. More specific questions related to best approaches to submitting RDoC-related grants and also the process for informing review committees about RDoC were discussed. Dr. Cuthbert reiterated that fundamentally RDoC is expected to be a living document, influenced by clinicians, science, and researchers. At the conclusion of the program, Dr. Drury suggested that RDoC and DSM can, and need to be, integrated. One perspective for child and adolescent psychiatry to consider is that RDoC is a call to test and challenge current paradigms and nosology. By doing so, we will be better positioned to advance scientific discovery and ultimately provide improved treatments to children and their families who are struggling with mental illness.

Dr. Drury is director of the Behavioral and Neurodevelopment Genetics Laboratory, in the Department of Psychiatry, Division of Child and Adolescent Psychiatry, at Tulane University School of Medicine. She may be reached at sdrury@tulane.edu.

Dr. Peterson is the director of the Institute for the Developing Mind at Children’s Hospital Los Angeles and director of Child and Adolescent Psychiatry at the Keck School of Medicine at the University of Southern California. He may be reached at bspmd61@gmail.com.

Simon Wile Symposium: Current State and Future Directions for Inpatient Consultation-Liaison Psychiatry

The Committee on Collaboration with Medical Professions sponsored the Simon Wile Leadership in Consultation Award honoring an American Academy of Child and Psychiatry (AACAP) member who has contributed to the field of consultation and liaison psychiatry in children. Simon Wile, MD, was a renowned pediatrician and champion for child and adolescent psychiatry. This year, Barry Sarvet, MD, the vice-chair of the Psychiatry Department, chief of Child and Adolescent Psychiatry at Baystate Medical Center, and associate clinical professor of Psychiatry at Tufts University School of Medicine, was honored for his dedication and innovation in creating collaborative care models between pediatricians and child and adolescent psychiatrists to meet the growing mental health care needs of children in the United States.

The overall goal of this year’s symposium was to update AACAP members on the variety of hospital-based consultation-liaison services provided in several settings. The invitees described the history and development of consultation services within hospital settings, embedded within a chronically medically ill population, and the expansion of these services beyond inpatient settings into continuous multidisciplinary outpatient treatment programs.

Susan Beckwitt Turkel, MD, opened the symposium with an expansive presentation on her 23 years in consultation-liaison psychiatry. Dr. Turkel eloquently discussed her experience as a child and adolescent psychiatrist at the Children’s Hospital Los Angeles (CHLA). She described engaging and developing relationships with different medical departments as a mechanism for growing and developing her consultation-liaison service.

In 2013, in collaboration with the AACAP Physically Ill Child Committee, a survey of consultation-liaison service directors was completed. In comparison to CHLA with three full-time and one part-time child and adolescent psychiatrists, most pediatric consultation-liaison services in the United States have a diverse staff consisting of psychiatrists, psychologists, social workers, and nursing staff. The patients served are medically complex, and represent a number of different pediatric specialties or illnesses, including oncology, cystic fibrosis, transplantation, autoimmune, and somatoform disorders.

As consultation-liaison services develop there is often integration of mental health services within medically ill populations. Georgina Garcia, MD, presented on the development of an embedded psychiatrist within a large cystic fibrosis (CF) center at Boston Children’s Hospital. Per a mental health survey of CF centers in the United States distributed by the Cystic Fibrosis Foundation, most CF centers have social workers as the primary providers of mental health care, with limited availability of psychologists and psychiatrists. Mental health screening is not
routinely done in centers and less than half of the centers use evidence-based interventions. Dr. Garcia described quality improvement projects that were conducted over a four year period aimed at improving the quality of mental health care for patients with CF. Dr. Garcia also described research collaborations looking at health care utilization of patients with CF and comorbid depression and exploring the relationship between depression and Vitamin D in patients with CF.

In 2011, the Children’s Hospital of Philadelphia (CHOP) developed a collaborative program between the Department of Child and Adolescent Psychiatry and Behavioral Sciences and the Division of Adolescent Medicine to diagnose and treat eating disorders. Laurel Weaver, MD, PhD, Leela Jackson, PhD, and Kenisha Campbell, MD, presented on the development of a multidisciplinary Outpatient Family-Based Systems Oriented Treatment for Anorexia Nervosa and Bulimia Nervosa.

Dr. Weaver discussed the barriers to providing coordinated medical and psychiatric care to patients with eating disorders. Patients with eating disorders admitted from inpatient Adolescent Medical units for malnutrition and medical stabilization are simultaneously assessed and diagnosed by the psychiatric consultation team. Then, when patients are discharged, they are followed as outpatients by both the Adolescent Medicine and Psychiatry clinics with an emphasis on family-based approach to treatment. Initial results of this program from 2011-2013 found that 48% of patients were able to be followed as outpatients by CHOP Department of Psychiatry. Of those patients admitted from 2011-2013, 48% of them were followed at CHOP outpatient. After initiation of outpatient treatment, 86.2% of the patients did not require a higher level of care for treatment of their eating disorder, 12.5% required a higher level of care, and 18.5% required medical readmission for medical stabilization.

The symposium closed with a presentation by the honoree Barry Sarvet, MD. Dr. Sarvet described the dire need for child and adolescent psychiatrists throughout the country to provide services for children. The Massachusetts Child Psychiatry Access Project (MCPAP) was developed to bridge the gap in care by providing pediatricians with psychiatric telephone consultation services in Massachusetts. Pediatricians can receive direct consultation, urgent psychiatric assessment, case coordination, and psychiatric referral services via MCPAP from the comfort of their office.

Following on the success of MCPAP, Dr. Sarvet is now chair of the National Network of Child Psychiatry Access Programs Committee. This network attempts to bring together mental health resources within each state, utilizing principles of MCPAP, in addition to other innovations, to amplify the mental health capacity of pediatricians. Dr. Sarvet presented initial data from participating states and discussed limitations and barriers to project development in some areas.

Warm congratulations to the Simon Wile Award winner Dr. Sarvet, for his dedication and innovations in integrating psychiatry with primary care to improve access to mental healthcare across the country. Additionally, Robert Hilt, MD, chair, as well as committee members Richard Martini, MD, Negar Beheshti, MD, and Maryland Pao, MD, should be commended for bringing together a diverse set of speakers who continue to redefine pediatric consultation-liaison services in the United States.

Dr. Garcia is in the Psychiatry Consultation Service at Children’s Hospital in Boston. She may be reached at Georgina.Garcia@childrens.harvard.edu.

AACAP's 62nd Annual Meeting takes place October 26-31, 2015, at the Henry B. Gonzalez Convention Center and Grand Hyatt San Antonio in San Antonio, Texas. Abstract proposals are prerequisite for acceptance of any presentation. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by Tuesday, February 17, 2015, or by Monday, June 15, 2015 for (late) New Research Posters. The online Call for Papers submission form became available at www.aacap.org in December 2014, and all submissions must be made online.

Questions? Contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
61ST ANNUAL MEETING RECAP

Clinical Perspectives Meets TED Talks

At AACAP’s 61st Annual Meeting in San Diego, the program Perspectives Meets TED Talks: (Clinical) Ideas Worth Spreading adopted the popular TED Talks format to present select topics previously published as Clinical Perspectives in the Journal of the Academy of Child and Adolescent Psychiatry. The appeal of TED Talks can be attributed to a style in which the speaker dynamically delivers the content using multimedia to punctuate the content rather than summarize it. Ultimately, the success of these presentations comes from the art of storytelling, in which the speaker uses anecdotes, humor, and clinical pearls to engage the audience. As promised by Andrés Martin, MD, MPH, and Laura M. Prager, MD, the program chairs, the audience was inspired by and connected to the content in a new way.

The first presentation, “Princess by Proxy,” by Martina Cartwright, PhD, from the University of Arizona, focused on the unhealthy culture of child beauty pageants. Dr. Cartwright wove her own professional biography, in which she started as a nutritionist for the Cirque de Soleil studying the nutritional habits of circus performers, into her presentation. This interest evolved to focus on eating disorders among child participants in beauty pageants. She identified three stages of child abuse. The first stage is risky sacrifice, in which the “stage mom” places the child in the center of her universe and engages in risky behavior while pursuing dreams of stardom. For example, exorbitant second mortgages are obtained to fund the cost of pageant participation. The second stage is objectification, in which the child star is sexualized through the application of heavy makeup and provocative clothing. Dr. Cartwright highlighted this phenomenon with images of Honey Boo Boo and Jon Benet Ramsey, which emphatically brought her point home. The third stage occurs when the “stage mom” directly harms the child’s physical health in furtherance of her own dreams, such as feeding the child amphetamines and pixie sticks containing sugar and caffeine to optimize performance and induce weight loss. Dr. Cartwright concluded her talk with recommendations to refer these families for psychiatric care and to turn off your TV.

Next, Peter Daniolos, MD, from the University of Iowa, spoke about Gender Dysphoria. He began with inspiring examples of successful transgender role models in the media, such as Laverne Cox, and the Supreme Court of India’s recent decision to legally recognize a third gender. He described the challenges of being transgender and society’s discomfort with and marginalization of transgender individuals. As a child and adolescent psychiatrist, Dr. Daniolos eloquently brought the audience into an experiential moment of empathy by discussing the importance of gender in the development of identity. The starting point of identity development may be fragile or even fractured in a transgender child. Hope followed empathy after a short education on gender terminology. Hope is evident in the increasing media acceptance of the transgender community even as gross protests to the contrary persist. Dr. Daniolos discussed symptoms and risk factors to help clinicians identify gender dysphoria, which included natal female gender, intense denial or hatred of one’s natal gender, and believing that one was the other gender. He concluded by sharing the uplifting experiences of his patients in successful treatment with sex hormones and gonadotropin inhibitors.

Continuing the theme of identity, Cortlyn Brown, BA, related her own story about the complexities of navigating society as a biracial woman. At first glance, Ms. Brown who is a medical student at the Yale University School of Medicine, has a Caucasian phenotype, with blond hair and light complexion. Her heritage, however, is African-American. Ms. Brown is the granddaughter of the late Homer S. Brown, who was the first African-American judge in Pittsburgh, Pennsylvania, and the daughter of the late Byrd Brown, a renowned leader in the civil rights movement and president of the NAACP of Pittsburgh during the turbulent 1960s. Ms. Brown led the audience on a tour of what it was like to experience her world of being perceived as a white woman when her identity was so grounded in her proud African-American legacy. She encouraged clinicians to inquire about the cultural experiences and identities of our patients. Ms. Brown graciously described the vulnerability amongst multi-racial youth caused by fragmented perceptions that create a sense of “dis-identity.”

In “Policing the Teen Brain,” Jeff Q. Bostic, MD, EdD, from the Massachusetts General Hospital, discussed a prevention program to help police officers better understand teenagers’ thinking and behavior. Dr. Bostic playfully made fun of the irrational expectation that the output of emotionally-driven teenage brains should be logical. He reviewed the neurobiological differences of adolescent brains as being preferentially dominated by the limbic system and the amygdala while the frontal and prefrontal cortex are actively being pruned and refined. By providing neurodevelopmentally-informed training to the police, Dr. Bostic and colleagues were able to markedly decrease the number of teen arrests in Boston. In 1998, a policy change mandated students in the Boston public school system to use public transportation to get to school. In 1999, Massachusetts Bay Transit Authority
officers made 646 juvenile arrests. By 2009, after Dr. Bostic’s training program was implemented, annual juvenile arrests fell to 74. As a result of the training, transit police officers improved their ability to negotiate nonsensical, confrontational, and/or risk-taking behaviors emanating from biologically immature teenage brains.

Pulling elements from each of the four other talks, Joseph A. Shrand, MD, from the Massachusetts General Hospital declared, “keep it frontal, don’t go limbic.” He urged for a perspective change to help clinicians form trusting therapeutic bonds with adolescents struggling with substance abuse. Every person desires to be valued by another. Empathy is the core ingredient in Theory of Mind. Dr. Shrand tied these ideas together, suggesting that patients “desperately” want to know what we think of them. Dr. Shrand adapted the concept of Imax – which in physics refers to the maximum current – to represent the maximum potential of any individual at any given time. There are four components impacting the value of Imax: home, social environment, biology, and self-concept, which includes the Theory of Mind. Treatments targeting any one of these fluid, interactive, and interchangeable elements can tremendously enhance one’s Imax. By embracing the perspective that everyone at any given time is functioning at their Imax, even at low moments, such as when patients are relapsing or lying to their parents, the clinician starts from a place of respect. Giving respect is valuing another, generating trust. Dr. Shrand reminded the audience, “we can’t change anyone but we can influence everyone.”

The TED Talks format broke new ground as each speaker engaged and inspired the audience. Given the audiences’ enthusiasm, we look forward to the next round of Clinical Perspectives - TED Talks in San Antonio, Texas, in 2016.

Cassie Yu, MD, is a child and adolescent psychiatry fellow in the Division of Child and Adolescent Psychiatry, Seattle Children’s Hospital and University of Washington, Seattle, Washington. She may be reached at Cassie.Yu@seattlechildrens.org.

Jon McClellan, MD, is a professor in the Department of Psychiatry, University of Washington, Seattle, Washington. He may be reached at drjack@uw.edu.

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To access speaker handouts from the Annual Meeting:
Log in to www.aacap.org, and then go to the 61st Annual Meeting homepage at www.aacap.org/AnnualMeeting/2014 and click on the link for Itinerary Builder.
Questions? Call 202.966.7600, ext. 2006
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Cartoon courtesy of David Schopick, MD
Rookie Reflections

Mona Noroozi, Communications and Marketing Coordinator

When the plane touched down in San Diego, California, I was overwhelmed by the prospect of returning to the community where I grew up and so long called home. As a California native, I had left behind friends, family, and all that was familiar to pursue my interest in health policy and advocacy in Washington, D.C.

It was not until my attendance at AACAP’s 61st Annual Meeting that I realized I had already cultivated a new home over the previous nine months with AACAP. The Annual Meeting provided me the first opportunity to experience the tightknit AACAP community at large, and gave me the realization that I had sincerely found an organization that aligned with my personal and professional beliefs.

Within moments of the registration doors opening, AACAP’s 61st Annual Meeting was in full swing. Coastline views and California sunsets served as a picturesque backdrop to engaging International and Welcome Receptions where attendees from over 53 countries converged to reconnect with old friends and meet new members of the AACAP family. The dedication and commitment by AACAP members who traveled far and wide to promote the healthy development of children around the world inspired stimulating presentations and discussions on a variety of issues in the field of child and adolescent psychiatry.

In my new role as liaison to the Military Issues Committee, I participated in an engaging discussion that benefitted from the varied backgrounds and experiences represented AACAP members from all over the nation and the world. Attendees engaged passionately in thought-provoking discussions on the critical importance of ensuring all children, regardless of socioeconomic background, gain access to quality and timely care. As a Washington, D.C. transplant, I found it most refreshing to observe passionate physicians who, regardless of political ideologies, sought resolutions to issues that prioritized patients over politics.

On a more personal note, I was deeply touched by the effort members made to connect with me—sharing stories, advice, and words of wisdom—and for all the encouragement and support they continue to provide me.

As this year comes to a close and a new one begins, I look forward to the opportunity to continue to build relationships with the many kind and generous members who make AACAP such a special organization.

It is a privilege to have taken part in AACAP’s 61st Annual Meeting—now, all that’s left to be done is prepare for our reunion in San Antonio, Texas, in October 2015!

AACAP Catchers in the Rye Humanitarian Award

Deadline March 13, 2015

Nominations are now being accepted for the American Academy of Child and Adolescent Psychiatry (AACAP)’s Catchers in the Rye Humanitarian Award. This award honors a non-AACAP-member who has made significant contributions to the field of children’s mental health. Contributions may include but are not limited to philanthropy, research, entrepreneurship, advocacy, increasing awareness, acts of bravery and kindness.

The AACAP Catcher’s in the Rye Humanitarian Award recipient will be recognized for their impact on children’s mental health at the 2015 AACAP 62nd Annual Meeting in San Antonio, Texas, from October 26th–October 31st. Recipients are required to attend the awards ceremony at the Annual Meeting.

All nominations must be submitted to the AACAP Development Office via email at development@aacap.org. Nominations must be in a Word document or PDF. Please write “AACAP 2015 Humanitarian Award Nomination” in the subject line of the email.

If you have questions about the award or the award process, please contact Alan Mark Ezagui, MHCA, AACAP Deputy Director of Development at 202.966.7300 ext. 130 or aezagui@aacap.org.
Members of the 100% Club  

Are you in?

The following child and adolescent psychiatry Residency Program Directors recruited all of their residents to AACAP. KUDOS to the following Program Directors for their efforts in recruiting 100% of their programs! All of their residents become AACAP members as of October 1, 2014.

Albert Einstein College of Medicine  
Louise Ruberman, MD

Ann & Robert H. Lurie Children’s Hospital of Chicago/McGaw Medical Center of Northwestern University  
Jennifer Kurth, MD

Baylor College of Medicine  
Laurel L. Williams, MD

Brown University  
Jeffrey I. Hunt, MD

Cambridge Health Alliance  
Sandra Defong, MD

Carilion Clinic-Virginia Tech Carilion School of Medicine  
Felicity Adams, MD

Children’s Hospital (Boston)  
Robert Kitts, MD

Children’s Hospital Medical Center of Akron/NEOMED  
Sumru A. Bilge-Johnson, MD

College of Medicine, Mayo Clinic (Rochester)  
Cosima C. Swintak, MD

Creighton University/University of Nebraska  
Jamie Snyder, MD

Drexel University of Medicine/ Hahnemann University Hospital  
Benjamin Spinner, MD

Duke University Hospital  
Gary Maslow, MD, MPH

Emory University  
Jennifer Holton, MD

Georgetown University Hospital/ Adventist Behavioral Health  
Matthew Biel, MD, MSc

Harlem Hospital Center  
Kareem Ghalib, MD

Icahn School of Medicine at Mount Sinai  
John D. O’Brien, MD

Indiana University School of Medicine  
David Dunn, MD

Institute of Living/Hartford Hospital  
Robert Sahl, MD

Louisiana State University  
Martin Drell, MD

Louisiana State University – Shreveport  
Rita Horton, MD

John Hopkins University  
Roma Vasa, MD

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Sandra L. Fritsch, MD

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Sandra Sexson, MD

Michigan State University  
Madhwi Richards, MD

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Rush University Medical Center  
Adrienne Adams, MD, MS

Southern Illinois University  
Ayame Takahashi, MD

St. Luke’s-Roosevelt Hospital Center  
Georgia Gaeviras, MD

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SUNY Health Science Center at Brooklyn  
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Faiza Qureshi, MD
Life Members Reach!

No, not 100 years old.
But, **100 lives you have impacted.**

**Impact.** In 2014, we approved **32 new grants, 17 residents and 15 medical students.** Which means that, since 2010, the Life Members Fund has made an investment in **54 residents and 46 medical students.** That’s potentially **100 next generation child and adolescent psychiatrists.** And, future Owls!

**More Impact.** 20 of the current 31 medical students awarded travel grants have graduated. **All 20 or 100% have matched in either psychiatry or pediatrics!**

**Donate.** This achievement is remarkable. We are at a time of health care change when our skills have never been more important, but the deficit of available child and adolescent psychiatrists is growing. Life Members can, and are, closing this gap. Let’s keep it up!

To donate, visit [www.aacap.org/donate](http://www.aacap.org/donate).

**Stay involved.** Stay connected to all Life Members activities, programs, and photos by reading the Life Members eNewsletter distributed quarterly online. Did you receive the latest Life Member eNewsletter in January?

NEW: There is another way you can donate and do more to close the gap. Learn about the **1953 Society.** It is a tomorrow investment, **made today.**

Visit [www.aacap.org/1953_Society](http://www.aacap.org/1953_Society) to learn more.

**2015 Owl Pin.** Remember, if you donate $450 or more to the Life Members Fund by October 31, 2015, you will receive a limited edition 62nd Anniversary OWL PIN!
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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300 ext. 130.
Distinguished Member Awards

Nomination Deadline: May 1, 2015

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: 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 the AACAP Annual Meeting, October 26-31, 2015 in San Antonio, TX.

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 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.

AACAP Paper Prizes

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.
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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.
Classifieds

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University of California, San Francisco

The Department of Psychiatry at the University of California, San Francisco, invites applications for an Attending Psychiatrist in the Child and Adolescent Psychiatry (CAP) Division, a Director of Outpatient Clinics in the CAP Division, and a Medical Director of the Division of Infant, Child, and Adolescent Psychiatry (ICAP) at San Francisco General Hospital (SFGH). Positions will be filled at an academic rank and series commensurate with experience, and are open now.

Applicants to the Attending Psychiatrist position must have an MD or equivalent, be board certified in Psychiatry, be board certified or eligible in CAP, and licensed to practice medicine in California at the time of appointment. Apply online at psych.ucsf.edu/cap-attending/.

Applicants to the Director of Outpatient Clinics must have an MD or equivalent, be board certified in Psychiatry and CAP, and licensed to practice medicine in California at the time of appointment. Apply online at psych.ucsf.edu/cap-clinics-dir/

Applicants to the Medical Director position must have an MD/PhD, MD or equivalent, completed training in General Psychiatry, board-certified or board-eligible in both General Psychiatry and Child Psychiatry, licensed to practice medicine in California at the time of appointment; demonstrated clinical, educational, and leadership skills with strong commitment to an academic career as a clinician-teacher; expertise in the clinical care of child and adolescent psychiatry patients; demonstrated cultural competence in working with underserved and culturally diverse populations; bilingual: Spanish and English (strongly desired). Applications will be accepted until the position is filled. Apply online at aprecruit.ucsf.edu/apply/JPF00109

ATTENDING PSYCHIATRIST, CHILD AND ADOLESCENT PSYCHIATRY

Langley Porter Psychiatric Hospital and Clinics, University of California, San Francisco, Department of Psychiatry

http://psych.ucsf.edu/cap-attending/

The Department of Psychiatry at the University of California, San Francisco, invites applications for a Child and Adolescent Psychiatry (CAP) Attending Psychiatrist at Langley Porter Psychiatric Hospital and Clinics. The position will be filled in the Health Sciences Clinical series at the Assistant to Full Professor level, with an anticipated start date of January 1, 2015 or thereafter. Applicants must have an MD or equivalent, be board certified in Psychiatry and CAP, and licensed to practice medicine in California at the time of appointment.

Applicants must have demonstrated clinical and educational experience, scholarship, and management skills in child and adolescent psychiatric services; demonstrated interest, commitment, and cultural competence in working with culturally diverse patient populations; and demonstrated teaching ability. Responsibilities will include serving as a CAP Attending; helping provide coverage in two Assessment Clinics—the Hyperactivity, Attention, and Learning Problems (HALP) Clinic and the Autism Clinic; starting a new short-term assessment and therapy clinic; providing a half-day of forensic service is desirable; engaging in innovation and continual improvements in clinical and educational realms; engaging in clinical scholarship; participating in teaching, supervision and assessment of trainees, and collaborating with training program directors in clinical curricular development for medical students, residents, psychology interns, postdoctoral fellows, or graduate students in a variety of disciplines.

Applicants are encouraged to submit their application electronically—including CV; three letters of reference; and brief statement describing current clinical, teaching, and scholarly activities, such as educator’s portfolio or up to three representative journal articles or book chapters to: Robert Hendren, DO, c/o Nancy Buenaventura at nancy.buenaventura@ucsf.edu. Applications will be accepted until the position is filled; however, the selection committee will begin reviewing applications immediately. UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Equal Opportunity/Affirmative Action Employer.
CHILD/ADOLESCENT PSYCHIATRIST: PRIVATE PRACTICE PARTNERSHIP OPPORTUNITY

Calabasas Behavioral Health
Los Angeles/San Fernando Valley

Calabasas Behavioral Health (CBH) is a well-established, inter-disciplinary behavioral healthcare practice looking for one outstanding child, adolescent, and adult psychiatrist to join our team. We have an extensive referral network with a new patient waiting list. We value quality over quantity and take pride in an approach that focuses on comprehensive coordination of care with other stakeholders in our patients’ well-being. Our support staff and Web-based EMR allows clinicians to have the time to work collaboratively within the practice as well as with community psychiatrists, psychotherapists, schools, and other health care providers.

A dynamic transcranial magnetic stimulation (rTMS) service is also an integral component of our practice. Candidates will be trained in TMS and will be part of the treatment team.

Responsibilities:
- Out-patient child, adolescent, and adult psychiatry.
- Collaboration with team members and attendance at weekly staff and clinical meetings
- Participation in our Transcranial Magnetic Stimulation (rTMS) service. Training will be provided.

Practice Setting:
Calabasas is an affluent suburb of Los Angeles in the northern San Fernando Valley. Nestled at the base of the Santa Monica Mountains, the area offers miles of hiking and biking trails, state parks and many other recreational opportunities. The local public school systems are among the highest performing in the state. Downtown Los Angeles, the Getty Museum, the Disney Concert Hall, Universal Studios, as well as the beaches of Malibu and Santa Monica are all 30-40 minutes away.

Qualifications:
- BC psychiatrist and BC/BE in Child and Adolescent Psychiatry.
- Training and interest in psychotherapy as well as psychopharmacology.
- Desire to work as part of a collaborative, multi-disciplinary team.
- Interest in assuming a leadership role in the practice and pursuing a partnership track.
- California licensed.

Benefits:
- Fully paid malpractice insurance
- 401-K with employer match
- Disability and life insurance
- Full partnership track following two to two and half years of employment.

Submit Applications To:
Joel Crohn, PhD
Calabasas Behavioral Health
23622 Calabasas Rd., Suite 301
Calabasas, CA 91302
Email: drjcrohn@calabh.com
Phone: 818-921-4300 X 4
Website Address: www.calabh.com

COLORADO ENDOWED CHAIR AND MEDICAL DIRECTOR OF CHILD AND ADOLESCENT PSYCHIATRY

MillicanSolutions, Inc.
Aurora, CO

On behalf of the Department of Psychiatry at the University of Colorado School of Medicine, The Division of Child and Adolescent Psychiatry, and Children’s Hospital Colorado, MillicanSolutions, Inc. is pleased to inform you of the inception of a national search for the Endowed Chair and Medical Director of Child and Adolescent Psychiatry at the Anschutz Medical Campus located in Aurora, CO.

The Division of Child and Adolescent Psychiatry is a vital and growing research and teaching section in the Department of Psychiatry at the University of Colorado School of Medicine. The Division has recently completed an ambitious strategic plan which includes recruitment of more than 10 faculty positions over the course of the next year. Based at the Anschutz Medical and Research Campus, the Section of Pediatric Psychiatry benefits from affiliation with world class inter-disciplinary professional education, research programs and clinical services.

The Child and Adolescent Psychiatrist must demonstrate clinical experience and excellence with children and adolescents and the ability to manage different levels of acuity, including psychiatric patients in inpatient and partial hospitalization settings, on the medical floors in consultation and liaison service.
in outpatient clinic, day treatment, and in the Emergency Department. Applicants must demonstrate the ability to apply and implement evidence based approaches to care. A history of teaching and mentoring residents, medical students, and working with milieu staff is also desired. Scholarly activities are encouraged and supported.

Applicants must possess a Colorado Medical License, DEA Certificate, Board Certified in Psychiatry, and be Board eligible in Child Psychiatry. Must obtain Medical staff privileges within Children’s Hospital Colorado. Must have prior experience in a Child Psychiatric setting, having completed a child/adolescent residency, academic/residency program related experience highly desirable. Must be board certified within 3 years.

Clinical experience in Child and Adolescent Psychiatry preferred. Leadership and teaching experience valued.

Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at www.cu.edu/pbs/.

Applications are accepted electronically at www.jobsatcu.com Job Posting #s F01221, F00563, and F01232.

Review of applications will begin immediately and continue until position is filled.

Submit Applications To:
Melissa Sinclair
Psychiatry Gary Pavilion Campus Box A036/B130, Rm D4128
Phone: 720-777-6203
Email: Melissa.Sinclair@ucdenver.edu

MISSOURI
WASHINGTON UNIVERSITY
IN ST. LOUIS NIMH T32
POSTDOCTORAL FELLOWSHIP
IN DEVELOPMENTAL NEUROSCIENCE AN
Early Emotional Development Program/Division of Child Psychiatry
St. Louis, MO
This full-time NIMH funded postdoctoral training fellowship is available to psychologists, neuroscientists, and both child and adult psychiatrists who are interested in conducting translational research on developmental neuroscience and child psychopathology, with a particular emphasis on early childhood. We will be recruiting at least two new trainees each year. The child psychopathology domains include, but are not limited to mood disorders, anxiety disorders, pervasive developmental disorders, ADHD, addiction, and psychosis. The training model for this fellowship focuses on interdisciplinary training, with trainees gaining expertise in both basic and clinical domains, including developmental psychopathology, developmental affective and cognitive neuroscience, genetics and developmental neuroimaging. Fellows will be mentored by Washington University faculty with international reputations in developmental psychology, clinical neuroscience, functional neuroimaging, psychiatric genetics, and cognitive and affective neuroscience. Fellows will be involved in didactic training in core areas, professional development training, and most critically, both ongoing and newly developed translational research projects. Washington University is an Affirmative Action Equal Opportunity Employer and encourages women, minorities, economically disadvantaged, and person with disabilities to apply. Applicants must have a PhD or an MD and must be citizens or permanent residents of the United States.

Salary for the position is based on the NIH Stipend Levels.

Submit Applications To:
Deanna Barch
Child Psychopathology Postdoctoral Fellowship, Washington University, 660 South Euclid, Campus Box 8134 St. Louis, MO, 63110
Phone: 314-747-2160
Fax: 314-747-2182
Email: dbarch@artsci.wustl.edu

Fellowship in Autism & Developmental Disorders

Maine Medical Center/Maine Behavioral Healthcare offers a 1 year fellowship to adult or child psychiatry graduates to develop in-depth knowledge in the assessment and treatment of children and adolescents with autism and other developmental disorders. The fellowship includes experience in our specialized inpatient, day treatment, outpatient clinic, telephone consult and research services.

Fellows receive a PGY-6 or 7 salary and benefits and begin July 1, 2015.

Inquiries to: Matthew Siegel, MD, Director
Center for Autism and Developmental Disorders
236 Gannett Drive, South Portland, Maine 04106
or siegem@mainebehavioralhealthcare.org,
www.springharbor.org/sphar_body.cfm?id=7453
DOUGLAS B. HANSEN, MD

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