Inside...

An Ally in the Music: How the Hip-Hop Sub-Culture Helps Us Understand Adolescents in the Inner City .................... 76

Making Blindness Visible to Child and Adolescent Psychiatrists .... 78

Disaster Planning and the Disaster Liaison Network ................... 80

Honor Your Mentor ................... 90

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Save the Dates

New Research Poster Deadline: 
**June 4, 2019**

Preliminary Program / Hotel Reservations: 
**June 14, 2019**

Member Registration Opens: 
**August 1, 2019**

General Registration Opens: 
**August 8, 2019**

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## TABLE of CONTENTS

### COLUMNS

- **Neera Ghaziuddin, MD, Section Editor • neerag@med.umich.edu**
  - International Relations Column: A Child Psychiatrist Returns from Malawi • George H. Stewart, MD .......................... 69
  - Acute Care Column: Opportunities for Psychiatrists to Decrease the Use of Seclusion and Restraint • Kim J. Masters, MD .................................................................................. 71

### COMMITTEES/ASSEMBLY

- **Ellen Heyneman, MD, Section Editor • eheyneman@ucsd.edu**
  - Diversity and Culture Committee: Inaugural Asian Caucus Meeting at AACAP’s 65th Annual Meeting • Yesie Yoon, MD, and Jennifer Rahman, MD ................................................................. 74
  - Consumers Issues Committee: An Ally in the Music: How the Hip-Hop Sub-Culture Helps Us Understand Adolescents in the Inner City • James Lubin, MD ........................................................................ 76
  - Deaf/Hard of Hearing and Blind/Low Vision Committee: Making Blindness Visible to Child and Adolescent Psychiatrists • Stephanie Sims, MD .................................................................. 78
  - AACAP Election Policy ............................................................................. 79
  - Disaster and Trauma Issues Committee: Disaster Planning and the Disaster Liaison Network • Martha J. Ignaszewski, MD ........................................................................ 80

### FEATURES

- **Alvin Rosenfeld, MD, Section Editor • arosen45@aol.com**
  - Notes from the 2018 Interim Meeting of the AMA House of Delegates • David Fassler, MD, Louis Kraus, MD, George “Bud” Vana, IV, MD, Soo Lee, MD, and Ronald Szabat, JD, LLM ............................................. 84
  - Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award Recap • Wynne Morgan, MD, and Christopher Bellonci, MD ........................................................................ 85
  - Psychodynamic Faculty Training and Mentorship Initiative • Rachel Ritvo, MD ........................................................................ 87

### HONOR YOUR MENTOR

- Honor Your Mentor .................................................................................. 90

### MEETINGS

- **Jon (Jack) McClellan, MD, Section Editor • drjack@u.washington.edu**
  - New Research Poster Call for Papers .......................................................... 98

### FOR YOUR INFORMATION

- **Communications & Member Services • communications@aacap.org**
  - Membership Corner .................................................................................. 100
  - In Memoriam .......................................................................................... 100
  - AACAP Catchers in the Rye Humanitarian Award ........................................ 101
  - Staff Recognition .................................................................................. 102
  - Welcome New AACAP Members ................................................................ 103
  - Thank You for Supporting AACAP! ........................................................ 104
  - AACAP Award Opportunities .................................................................. 108
  - Classifieds ............................................................................................ 110

**Cover:** This photo is of an Hmong girl in Vietnam selling jewelry at a market. She is a member of an ethnic group living primarily in Laos, China, and Vietnam.

– Howard Rudominer, MD
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

Child and adolescent psychiatrists are the leading physician authority on children’s mental health. For more information, please visit www.aacap.org.

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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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A Child Psychiatrist Returns from Malawi

George H. Stewart, MD

I have just returned from Malawi after two years as a Seed Global Health-Peace Corps volunteer (Global Health Service Partnership), teaching at the College of Medicine and working at Queen Elizabeth Central Hospital, a 1,300+ bed teaching hospital. (See my first article, “A Child Psychiatrist in Malawi” in the November/December 2016 issue of AACAP News.) I am now writing from my summer cabin, looking down the meadow towards the harbor, on a small island 6.5 miles off the coast of Maine.

I just turned 78 years old. I am reasonably fit and my partner, Linda Robinson, and I hiked and camped all around Southern Africa during our holidays, including in Malawi, South Africa, Mozambique, and, for the past two months, in Namibia, Zambia, and Botswana. Southern Africa is wondrously beautiful, filled with all manner of animals, birds, lovely people, and surprises of the good kind. It is also remarkably easy to travel. Want to see 30 wildly colorful white-fronted bee eaters feeding their young in little riverbank caves on the Zambezi? Or lions and leopards stalking and eating their prey while their cubs suckle? Or fly in an ultralite over Victoria Falls? On and on and on.

As to the work, it is always difficult to assess what impact we may have had. I certainly helped individual patients whom I saw directly, some definitively. I taught adult, adolescent, and child psychiatry in seven week blocks to groups of 22 fourth year medical students, lecturing, facilitating role plays and problem-based learning exercises, and, perhaps most useful for them, mentoring them in their clinical work. They learned how to take a psychiatric history, how to perform a mental state exam, how to formulate a problem, how to make a reasonable diagnosis, and the beginnings of creating a treatment plan in both the Adult and Pediatric Mental Health Clinics. They also learned how to present a case, how to self-observe and to use those observations in their work, and how to be calm and respectful no matter how outrageous a disturbed patient was. They learned, so crucial in Malawi where infectious diseases including HIV are so prevalent, how to distinguish delirium—“an acute confusional state”—from “functional” psychiatric illness, so that patients with underlying medical illness could receive prompt and definitive treatment. So, I think a number of our students will practice safer, better quality medicine when they graduate.

The stresses of my experience were numerous: the near-constant novelty, power and water outages, stock-outs of medications, very limited psychopharmacology formulary, decrepit state of the facilities, and lack of social or special educational services to help with recovery and reintegration. And always, the terrible inequality of wealth, with most people having no housing, job, health, or food security. The knowledge that I can always buy a ticket and fly away to the Land of the Free, Home of the Brave was a two-edged blade.

The three nurses I worked with were very good, long on experience in their system, and I learned considerably from each of them. The three registrars (residents) were capable and eager to learn; although at times they felt burdened by a workload I could only have dreamed about in my training. My counterpart, a UK-trained psychiatrist, was very bright and hard-working. (He’s just returned to Vienna for the birth of his twins, so I suspect he’s stepped from the frying pan into the fire!)

I gave a short course to our nurses and registrars on child and adolescent psychiatry and developed a two-room Pediatric Mental Health Clinic under my direct supervision at Queens. We worked closely with the Pediatric Emergency Department and the Department of Pediatrics from which many of our referrals derived. Since sustainability is the first criterion for any new initiative, especially in a low-resourced country, my aim was to use the clinic as a training site, which we did, for nurses, registrars, and medical students. Situations were often heartrending, as with the many...
A Child Psychiatrist Returns From Malawi  

continued from page 69

children who suffered cerebral malaria as infants and toddlers and who were seriously cognitively impaired. Special services, including special education, are rarely available. After helping a parent to cope with their grief, anger, and disappointment about their brain-damaged child, we trained them to patiently train their children. There was the 13-year-old boy whose uncle castrated him, penis and testicles, at six years of age to sell his “parts” for potions in S. Africa. Or the boy whose friend’s mother went berserk and attacked him with a panga knife (machete), making deep lacerations all over his body, fracturing his tibia, giving him a subdural hematoma, and with resultant severe posttraumatic stress disorder (PTSD). Or the little boy, of indeterminate age, who was found living with baboons and was repeatedly sodomized by some charcoal burners who worked nearby in the woods. And on and on! There is, fortunately, an excellent service for sexually abused children, the One Stop Center, where, as the name implies, evaluation, medical and psychological treatment, and legal services are all provided. Sexual abuse seems fairly common, although enforcement of the laws is very weak, and it is rarely reported (and, thus, rarely recognized). When a 15-year-old girl presented with constant urinary incontinence for two years, she was hospitalized twice for urological workups until, finally, someone sent her to our clinic where the correct diagnosis and treatment were given.

Malawi is known as “The Warm Heart of Africa.” People are incredibly friendly. Although because of the job shortage and poverty, there is some theft, we were never robbed. There is little violent crime and no guns. It is nothing like Berkeley, Oakland, or Richmond, where I have lived for 45 years. I never felt threatened, except by speeding vehicles on the highway, whether I was on my bike, in my car, or riding in a minibus (my record is 24 people crammed into one, with a maximum of 15 seats!).

When I was a fourth year student at Columbia Medical School, a congressman, who was also a physician, gave a talk. He said, “I decided after my internship to go to an apple orchard without any pickers. I went to Taiwan and helped to develop their entire public health system.” What an opportunity! On a smaller scale, I feel the same. I have seen incredible illness and strength. I have heard fascinating tales from another world. And I have made deep connections with people whose lives have been dramatically different from my own. I suppose I am saying I had a rare opportunity to experience the Family of Man.

Dr. Stewart is an adult, adolescent, and child psychiatrist and a psychoanalyst living in Bar Harbor, Maine. Starting December 2018, he will be a Fulbright Scholar for a year, teaching child psychiatry at Medical University 1 in Yangon, Myanmar. His experience in Malawi can be reviewed on his blog at apsychiatristinmalawi.com. He may be reached at georgehstewart000@gmail.com.
Opportunities for Psychiatrists to Decrease the Use of Seclusion and Restraint

Kim J. Masters, MD

There have been major reductions in the use of seclusion and restraint since 2000 as the result of regulatory guidance, the adoption of programs in trauma-focused care, and collaborative problem solving. Nonetheless, reports of abuse, including one death in residential treatment centers (RTC), continue. These reports made no mention of psychiatric involvement, which raises the question of whether psychiatric intervention is important in prevention effort.

I have made informal inquiries of some members of AACAP’s Inpatient, Residential & Partial Hospitalization Committee and some staff who oversee regulations in psychiatric hospitals to answer this question as well as to survey the literature. Here is what I have found to date.

Regulatory Issues 2019

A recent Centers for Medicare and Medicaid Services (CMS) proposal to stop facility reporting of seclusion and restraint hours is based on data which shows very little change or differences between facilities. It was withdrawn thanks, in part, to objections from AACAP and others.

The CMS Final Rule of 2006 permitted the replacement of the psychiatrist in the following activities, without apparent patient harm.

- One hour reviews could be performed by trained nurses and other licensed practitioners (nurse practitioners, physicians assistants, non-psychiatrist MDs).
- Debriefing with staff and patient could be performed by licensed practitioners.
- 24 hour reviews generally were performed by a psychiatrist, although the use of other licensed practitioners was permitted.

Other Areas of Care Possibly Affecting Seclusion and Restraint Use and Abuse

There is apparently no required training in medical school or psychiatric residency on trauma-focused care or collaborative problem solving to permit understanding and de-escalation of confrontations. It is left up to individual programs or hospitals to provide this information. It is not clear which staff provide the education, but in the hospitals and RTCs I surveyed, either human resources or nursing was charged with this responsibility. I did not find facilities where psychiatrists did this training.

Many hospitals and RTCs require a management of aggressive behavior program for staff, like the Crisis Prevention Institutes Non-Violent Crisis Intervention or Cornell’s Therapeutic Crisis Intervention, to manage crisis de-escalation and to initiate seclusion and restraint. These programs differ across facilities, are not taught by psychiatrists, and do not necessarily require MDs to complete them.

Debriefings by staff that occur after seclusion and restraint episodes do not require the attendance of a psychiatrist. Although they are documented in the medical record, there is no requirement that psychiatrists review these findings with their patients.

There are also patient safety matters that fly under the regulatory radar:

- Admission Criteria: Although required of all facilities, they can often conflict with other issues, for example, financial concerns like whether the patient has private insurance that pays more than Medicaid, to keep beds full, and as favors to referral sources. Under these pressures, the criteria can become elastic. In one situation in which I was involved, being pressured to admit a four-year-old to a child unit when the program accepted only those who are five, or risk losing future referrals from an important outpatient psychiatrist.

- Acuity Ratings: The ratings are usually done each shift by nursing staff to assess staffing needs. However, even when the need for more staff is indicated, there may be no staff available. Psychiatrists generally do not contribute to rating assessments. Yet, if an agitated child is admitted to a volatile unit, increase in the risk for violence and restraint and seclusion procedures could be a consequence.

The cited news articles refer to both of these issues, especially extremely disruptive patients, in explanation of abuse complaints, suggesting that psychiatrist oversight of these procedures might help to decrease abuse opportunities.

- Safety plans: These are a variant of Psychiatric Advance Directives, whose purpose is to use methods identified prior to admission to help individuals with de-escalation. Admitting staff are supposed to be informed of their specifics and to incorporate them in treatment plans. Psychiatrists could enhance the plans effectiveness, through patient and family discussions and in treatment team reviews.

- Staff selection: In my opinion, the staff barrier that contributes most to recruitment and retention of highly trained professional behavioral health technicians (BHT) and residential...
Opportunities for Psychiatrists to Decrease the Use of Seclusion and Restraint continued from page 71

The average hourly salary of the former is around $13.10, while the latter is $10.78. These do not increase significantly with years of service. This reimbursement compares unfavorably with other hourly pay scales, most of which have lower stress and injury (ex. postal worker $20, software developer $32, customer service representative $17, Verizon sales associate $14).9

In addition to a lower salary, the mental health and residential care staff have stress levels complicated by the psychiatric issues of their charges - abuse from patients, lack of support from their employers - and the likelihood of being fired and prosecuted for misapplication of seclusion and restraint. No wonder many facilities have recruitment problems and turnover rates of up to 30% per year!

Although the salary levels and the hiring and firing of employees is an institutional function, if seclusion and restraint abuse is related to employee salary and education, then it is a concern that psychiatrists should highlight, both in discussions with administrators and in academic venues. There is precedence for raising these indirect clinical issues; both Pinel and Gardiner Hill identified staff abuse of patients as a major safety issue, as well as Bronfenbrenner’s Ecological System Theory. In this model, the child is surrounded by several layers - control life events - the family, school, and religious systems as the innermost layer, the local culture and community the middle layer, and for our purposes, institutional issues such as the setting of job qualifications, salaries, and regulatory issues of employment as the outer layer.11 The physician’s advocacy in the inner and middle arenas is current child psychiatry practice. I would propose that involvement in the third level as it relates to psychiatric institutions and their employees should be a public health issue when it has the potential to harm patients. In this context, employment conditions of behavioral health and RTC workers could be considered a primary prevention issue as it may be a factor promoting seclusion and restraint use that is not currently addressed by regulations and should be a concern of the psychiatrists treating patient in these settings.

**Conclusion**

There are a variety of interventions that can improve psychiatric oversight of seclusion and restraint and provide more opportunities to promote safety in child inpatient and residential units. In the end, awareness is the key to progress in preventing abuse.

**References**


Dr. Masters is a consultant 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; as well as in the Psychiatry Department and the Physician’s Assistant program at Wake Forest Medical School Winston Salem, North Carolina. He may be reached at kmaster105@gmail.com.
AACAP’s Legislative Conference and Assembly Meeting

May 2-4, 2019

AACAP’s 2019 Legislative Conference and Assembly Meeting will take place in Washington, DC, from May 2-4, 2019. Join us for both events to advocate for children’s mental health.

AACAP Legislative Conference
On May 2-4, AACAP’s Government Affairs team will teach you about the legislative process, provide you with advocacy materials to help you develop and deliver the most impactful messages, and schedule your meetings with legislators on Capitol Hill. Join us as we advocate for children’s mental health, and make your voice heard!
Visit www.aacap.org/LegislativeConference for more information or contact Harry deCabo, Advocacy & PAC Manager, at decabo@aacap.org or 202.587.9669.

AACAP Assembly Meeting
On May 4, AACAP’s Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.
Visit www.aacap.org/Assembly for more information or contact Megan Levy, Executive Office Manager, at mlevy@aacap.org or 202.966.1994.

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Inaugural Asian Caucus Meeting at AACAP’s 65th Annual Meeting

2018 was a historic year for Asian representation in the media. In movies, from Crazy Rich Asians to Searching to Kim’s Convenience, Asian representation not only increased in numbers but in its various reflections of Asians playing leads that break the traditional stereotypes. When Nora Lum, also known as Awkwafina, hosted “Saturday Night Live” as the first Asian woman to host since 2000, she noted that seeing Lucy Liu 18 years ago on television “changed what I thought was possible for an Asian-American woman.” This was long overdue, but still meaningful to the 20.5 million Asian-Americans who are the fastest growing ethnic group in the nation.

On October 25, 2018, Asian representation expanded at AACAP’s 65th Annual Meeting at the Washington State Convention Center in Seattle, Washington. The inaugural meeting of the Asian Child and Adolescent Psychiatry Caucus was held in a packed conference room of attendees and AACAP members. The founding members, Jang (Jean) Cho, MD, Annie Li, MD, Neha Sharma, DO, and Steven Sust, MD, started the meeting with an introduction of themselves, stories behind how this caucus started, and what it is aiming to achieve. Support for our caucus from AACAP was reflected by the presence of AACAP’s President Karen Dineen Wagner, MD, MPH, and Chair, Assembly of Regional Organizations of Child and Adolescent Psychiatry, Debra E. Koss, MD, Ranna Parekh, MD, MPH, Deputy Medical Director and Director of Division of Diversity and Health Equity at the American Psychiatric Association (APA), also joined us to advocate for opportunities such as the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Minority Fellowship Program (MFP).

Throughout the meeting, the audience was invited to engage through a smartphone-based interactive poll to see where attendees were coming from, how individuals identified themselves ethnically, where they were in their careers, and what areas of interest they brought to the meeting space. Laughs and whoops erupted as individuals saw their answers pop up on the screen. The poll result showed that most of the attendees were early-career psychiatrists (34.0%), mid-career psychiatrists (27.7%), and CAP fellows (25.5%) (Figure 1). The excitement and inclusive atmosphere allowed members of all backgrounds to speak up and voice their interests for advocacy work (34.8%), networking opportunities (30.4%), mentorship (15.2%), research collaboration...
(13.0%), and clinical guidance (6.5%) through this caucus (Figure 2).

A message of revolution and change permeated the room as faculty members offered mentorship for trainees while raising awareness of stigma both amongst patient populations and within other medical subspecialties. Calls for partnerships with other diversity and inclusion sub-committees and for future cross-collaborative meetings were discussed as well.

Methods of continuing the conversation and brainstorming ways to develop areas of interest include an email listserv to engage the community as well as quarterly conference calls to update projects and interests. The first conference call on January 8, 2019, invited all caucus members, including those who did not make it to the inaugural meeting in October, to participate and chime in about ideas for future meetings. Participants reviewed the goals of the caucus and brainstormed ideas to represent the goals of the caucus at the next Annual Meeting in Chicago. If you are interested in joining AACAP’s Asian Child and Adolescent Psychiatry Caucus, send an email to aapichildpsych@googlegroups.com to join our diverse and exciting group of Asian AACAP members.

Dr. Yoon is an assistant professor in child and adolescent psychiatry and general pediatrics at University of Alabama at Birmingham. She moved from South Korea in 2011 for triple board training, and continues to work closely with Asian-American students, trainees, and patients as an early-career psychiatrist in the United States. She may be reached at yoon@uabmc.edu.

Dr. Rahman is currently a first year child and adolescent psychiatry fellow in the NY Presbyterian Columbia-Cornell. She completed general training at the Zucker Hillside Hospital at Hofstra/Northwell Health, and medical training at SUNY Upstate Medical University. Areas of interest include cultural psychiatry, perinatal health, neurodevelopmental disorders, and early treatment psychosis, as well as play therapy and transitional age youth. She may be reached at jer9221@nyp.org.
An Ally in the Music: How the Hip-Hop Sub-Culture Helps Us Understand Adolescents in the Inner City

Growing up in inner-city Brooklyn, I was greatly influenced by hip-hop. For my peers and me, hip-hop was more than a music genre – it defined our culture, taught us what was “cool,” and affected everything from our communication to our style of clothes to our thoughts and behaviors. Over the years, I have watched my fashion change from du-rags and Sean John velour tracksuits with all white Nike Air Force Ones to slimmer-fitting clothes, all because of hip-hop trends. Even as I walked down the aisle at my medical school graduation ceremony, Drake’s 2013 anthem “Started from the Bottom” echoed in the back of my mind.

Hip-hop’s influence has increasingly permeated the mainstream, expanding from its underground coastal inner-city roots to the hollers of West Virginia, affecting youths from all ethnic and socioeconomic backgrounds. Remember when “bling bling” was added to the Oxford English Dictionary? Or perhaps you have heard adolescents using hip-hop jargon such as “facts,” “dab,” “lit,” “troll,” or “keeping it one hundred”? While adulthood and a career in medicine have diluted the less-subtle aspects of hip-hop’s influence on my life, my knowledge of the hip-hop subculture has proven invaluable in several unique cases, and it has been gratifying to understand my patients through this shared cultural lens.

Over the past few years, a number of older adolescents have presented to our psychiatric emergency room in inner-city Brooklyn, NY, with eerily similar presentations. Each was an aspiring rap music artist, who developed an odd preoccupation with secret societies. As their fixations with the occult started to consume them, their unsettled family members, desperate for answers, brought them to the emergency room (ER). These adolescents often harbored ego-dystonic thoughts of killing their best friend or a loved one. Family members would report finding odd things around the house, such as candles and knives hidden in the patient’s bedroom. These objects were gathered to be used in ritualistic ceremonies for the purpose of “selling their souls to the devil,” or making a sacrifice to the Illuminati, in exchange for success in the music industry. They believed that all renowned rap artists belonged to secret organizations, and that this was a necessary step for their initiation.

Not surprisingly, these teens were often heavily under the influence of illicit and prescription drugs, e.g., synthetic marijuana, benzodiazepines, and lean (a drink consisting of promethazine and codeine, usually mixed with sprite and other fruit-flavored additives). While grandiose delusions and preoccupations with the occult are not unique to the hip-hop community, I did have some insight as to why the frequency of these psychotic presentations might be increasing in the inner city, and perhaps across the country.

From its incipience, the counterculture of hip-hop has been closely associated with drug culture. While early rap artists in the 1980s often detailed the destructive nature of the crack epidemic, the music industry in the 1990s and 2000s glorified and perpetuated the archetype of the rapper/drug-dealing hustler, giving rise to influential figures such as Notorious B.I.G., Snoop Dogg, Jay-Z, and 50 cent. While references to alcohol, marijuana, and cocaine remain the most prevalent, over the past several years, hip-hop music has increasingly embraced the recreational use of prescription benzodiazepines, opioids, lean, synthetics, and MDMA (often referred to as molly). In Future’s chart-topping song, “Mask Off,” the main chorus repeats “Percocet, Molly, Percocet…” It is not uncommon to see adolescents on our inpatient units dancing and reciting these, and often more vulgar, lyrics.
Even within the hip-hop community, the trend towards more prescription drug use and their glorification in the music has begun to raise alarm, as the community has suffered a recent string of high-profile overdose and drug-related deaths, such as that of Lil Peep, Mac Miller, and Fredo Santana. These tragedies have raised awareness of the dangers of abusing benzodiazepines, opioids, lean, and other substances—particularly when used in conjunction as they often are. Many artists, such as Meek Mill, have begun to speak more openly about their personal struggles with substance abuse, and opioids in particular. Often, many of these artists admit that they did not know about the addictive potential of lean and opioids, and many of our adolescents are naïve to these risks as well.

During treatment rounds, as I would share my perspective with the treatment team on these cases, I would eventually have to explain why and how I knew so much about their behavior and seemingly obscure references. I was pleasantly surprised by how well this input was received by the team, and felt silly for shying away from a part of my identity that helped me relate to the population that I serve. A pediatrician might not be worth their weight in gold if they were unfamiliar with Dora the Explorer. Similarly, while 6ix9ine, Cardi B, and Chief Keef may not be palatable to everyone, some knowledge of key players and trends in the hip-hop community may provide information that can be leveraged to help communicate with children and adolescents, and better identify those at increased risk for substance use or even violence.

By learning about the prevalent themes in the music that our children and adolescents listen to, we can develop a more nuanced understanding of the social pressures they face, and help educate them such that they can make more informed decisions. A truly comprehensive history should include a thorough examination of the patient’s after-school activities, interests, and sub-culture identifications. This can be accomplished by showing genuine interest in our patients and their hobbies, asking them to educate us about their culture, and familiarizing ourselves with popular trends. As physicians, by stepping out of our comfort zones and into theirs, we may be able to form stronger therapeutic alliances and provide better treatment to this vulnerable population.

Dr. Lubin is a second year child and adolescent psychiatry fellow at SUNY Downstate Medical Center in Brooklyn, NY. He is a member of AACAP’s Consumer Issues Committee. He may be reached at James.Lubin@Downstate.edu.

For more information on CASII, contact the Clinical Practice Program Manager at clinical@aacap.org.
Making Blindness Visible to Child and Adolescent Psychiatrists

Stephanie Sims, MD

A

ACAP has had a thriving Deaf and Hard of Hearing Committee for the past 25 years, helping to inform members about the psychiatric, psychological, medical, developmental, educational, and remedial needs of children who are deaf or hard of hearing. This committee has helped to educate AACAP members about the ethical and clinical considerations in the assessment and treatment of deaf youth, including a cross-cultural immersion and clinical practicum at the 2017 Annual Meeting done in conjunction with Gallaudet University, a private university for the education of deaf and hard of hearing students in Washington, DC.

While AACAP has spearheaded efforts to promote awareness of the needs of deaf/hard of hearing youth, there was a notable gap in awareness and advocacy for youth with blindness/low vision. Epidemiological data on rates of blindness and visual impairment in the United States are lacking; therefore, the Centers for Disease Control and Prevention is currently developing the National Vision and Eye Health Surveillance System (VEHSS) to estimate the prevalence of eye disorders in the United States. Recent data from the National Survey of Children’s Health (NSCH 2007-2012) found that 1.7% of children in the United States have been told that they have a vision problem that cannot be corrected with glasses or contact lenses.

A common misconception about blindness is that it is an all-or-nothing phenomenon, when in actuality, most individuals with visual impairment still have residual vision. There are no universal definitions for blindness or visual impairment. While the World Health Organization (WHO) defines blindness as acuity less than 20/400, the United States defines legal blindness as acuity less than 20/200. The causes of pediatric visual impairment are heterogeneous and varied. Causes of pediatric visual impairment can be congenital or acquired and can affect the central nervous system or the eye itself. Different aspects of vision can be impacted such as peripheral, central, color, or night vision. In the United States, common causes of visual impairment in children include cortical visual impairment, retinopathy of prematurity, optic nerve hypoplasia, albinism, and optic nerve atrophy. Pediatric visual impairment can also be a part of a broader syndrome (such as Patau, Down, WAGR, or CHARGE syndrome). For example, over half of individuals with Down syndrome have some form of eye disease including congenital cataracts, keratoconus, nystagmus, refractive errors, strabismus, and amblyopia. Some children with visual impairment additionally have varying degrees of hearing loss, and individuals with combined deaf-blindness also have unique developmental and communication needs.

It is important for child and adolescent psychiatrists and mental health professionals to be aware of the unique psychiatric, psychological, developmental, and educational needs of this population. Vision impairment can affect developmental progress across a number of domains, including communication, language development, mobility, well-being, social interaction, and participation in age-typical activities. Attachment between parent and child can be affected due to limitations in facial recognition, eye-to-eye contact, and social smile. Language development can be affected by limitations in understanding joint reference and symbolic representation. Blind children can exhibit behaviors that mimic autism such as stereotypic rocking, echolalia, and immobility. Blind children are dependent on their caregiver to help them integrate their environment. In addition to effects on development, pediatric blindness can have effects on mental health. Psychological themes affecting youth and their parents/families in coping with visual impairment can include grief and loss, compensation, and identity. Previous studies investigating the impact of visual impairment on children’s mental health are limited. There have been studies showing higher rates of depression amongst visually impaired children and adolescents. Further studies are needed to investigate psychological strengths and vulnerabilities amongst youth with visual impairment.

Issues pertinent to child and adolescent psychiatrists include identifying typical and atypical development in children with visual impairment, improving identification and treatment of mental health disorders in youth with blindness or low vision, assisting youth and their families in coping and adjusting to vision loss, assisting parents in advocating for their children in the community and in schools, and promoting resilience for affected youth and their families.
In an effort to promote advocacy and education for AACAP about the mental health needs of youth with blindness and low vision, in spring 2018 the co-chairs of the committee, Jana Dreyzehner, MD, and Karen Goldberg, MD, and I proposed that AACAP incorporate the needs of youth with blindness and visual impairment into the existing committee. We submitted a letter proposing a new combined committee which would be renamed the Deaf/Hard of Hearing and Blind/Low Vision Committee. In July 2018, AACAP’s president, Karen Dineen Wagner, MD, PhD, and the Executive Committee officially approved this change. At the 2018 Annual Meeting in Seattle, we presented a Clinical Perspectives session on the mental health needs of blind and visually impaired youth. To the best of our knowledge, this was the first presentation to AACAP about this population.

The Deaf/Hard of Hearing and Blind/Low Vision Committee will address the needs of youth with visual and hearing impairments and guide AACAP with presentations at Annual Meetings that provide clinical and education information regarding this population. The committee will also develop curricula for training programs and encourage further research efforts in the field of identification and treatment of mental health issues in this population. Through these efforts, the committee seeks to make blindness visible to child and adolescent psychiatrists and illuminate the clinical challenges and unique needs of this population.

References

Dr. Sims is assistant professor of psychiatry at the University of Florida College of Medicine in Jacksonville. She is a member of AACAP’s Deaf/Hard of Hearing and Blind/Low Vision Committee. She has a vested interest in advocating for the mental health needs of children, adolescents, and adults who are blind and visually impaired. She may be reached at Stephanie.sims@jax.ufl.edu.

AACAP Election Policy
(approved by the Executive Committee March 23, 2001)

The ballot to elect President-Elect, Secretary, Treasurer, two Councilors-at-Large, and two Nominating Committee members is sent in May 2019. The election ends May 31, 2019. Ballots will be held for three months after the election, during which time anyone who wishes to contest the election can do so. After three months the ballots will be destroyed.

CAMPAIGNING IS PROHIBITED IN AACAP ELECTIONS
Disaster Planning and the Disaster Liaison Network

Martha J. Ignaszewski, MD

2018 was a challenging year for Americans and American families. Beginning with the tragic school shooting in February at the Marjory Stoneman Douglas High School in Parkland, Florida, gun violence has been a constant in 2018. According to the Gun Violence Archive, there were an estimated 340 mass shootings in the United States with an estimated 3,980 children or adolescent injuries or deaths. Simultaneously, the growing impact of climate change has wrought devastating natural disasters. These have ranged from violent snow storms in the Northeast, the devastating impact of Hurricanes Florence and Michael across the Eastern Seaboard, and ongoing deadly wildfires in California, which have resulted in hundreds of deaths and thousands of Americans who have been injured and displaced.

A disaster is understandably frightening and often overwhelming to children and adults, alike. AACAP’s 2013 Practice Parameter on Disaster Preparedness highlights the importance for families and providers to be aware of the “best approaches for assessment, [response] and management of children and adolescents across all phases of disaster.” Evidence indicates that over 65% of children experience at least one trauma, and over one-third of U.S. children experience multiple traumas in their lifetime, leading to a spectrum of negative psychological, emotional, behavioural, social, and somatic consequences and stress responses. For many children, disasters, with all their inherent complexities such as loss of community, home, and school, may be the traumatic experience that “puts them over the edge” or in and of itself results in a range of symptomatology. Rates of posttraumatic stress disorder (PTSD) have been shown to increase in response to major disasters. Despite these alarming statistics, child psychiatrists receive limited training in trauma-focused, evidence-based assessment and treatment.

“Mental health providers are a critical resource to traumatized children and families with invariable involvement irrespective of treatment setting, time from the disaster, or specific role.”

Though state and local agencies primarily execute and oversee disaster management, volunteers play a vital role in the post-impact period providing humanitarian and organization needs. Mental health providers are a critical resource to traumatized children and families with invariable involvement irrespective of treatment setting, time from the disaster, or specific role. Impacted children will be seen in primary care, emergency departments, clinics, and private practices for many years after the disaster experience. Given the increasing numbers of disasters and the long-standing effects of trauma, it is inevitable that child and adolescent psychiatrists will be involved in the care of this vulnerable population. We need to be familiar with our own resources, create relationships ahead of time, and obtain skills training to best engage with our local communities as caregivers before, during, and after disasters. Advance preparation and long-term follow up are frequently overlooked but are highly important aspects of recovery in which we can make meaningful contributions.

From the onset, interventions should include screening, assessment, monitoring, family outreach, psychoeducation, and promoting connectedness. Providing anxiety reduction techniques using a multimodal approach and addressing sleep issues are useful initial treatments. Working closely with other child serving systems such as schools and pediatrics is a necessary strategy during the aftermath of a disaster. Comfort with social media and news outlets provides an effective mechanism for the distribution of accurate information, offers public education, can extend the reach of providers, and may help combat stigma. Later treatment may include ongoing psychotherapeutic engagement and implementation of psychopharmacologic considerations.

Last year, the Disaster and Trauma Issues Committee was the recipient of AACAP’s Assembly Catchers in the Rye Award to a Component, presented at the Annual Meeting in Seattle. The Disaster and Trauma Issues Committee has been involved in advocacy pertaining to issues of disaster and trauma with children and adolescents through member awareness, encouragement of appropriate training experiences, and collaboration with national health organizations and regional councils. The committee also is responsible for helping to curate the Disaster Resource Center on AACAP’s website, which provides the most relevant and up-to-date information through social media engagement to help families in talking to children about disasters.

Given the ongoing disaster climate, we encourage all of AACAP’s membership to better acquaint itself with the Disaster Resource Center and encourage local involvement with disaster relief organizations, such as the American Red Cross and the Medical Reserve Corps. The National Child Traumatic Stress

COMMITTEES/ASSEMBLY

DISASTER AND TRAUMA ISSUES COMMITTEE

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From the onset, interventions should include screening, assessment, monitoring, family outreach, psychoeducation, and promoting connectedness. Providing anxiety reduction techniques using a multimodal approach and addressing sleep issues are useful initial treatments. Working closely with other child serving systems such as schools and pediatrics is a necessary strategy during the aftermath of a disaster. Comfort with social media and news outlets provides an effective mechanism for the distribution of accurate information, offers public education, can extend the reach of providers, and may help combat stigma. Later treatment may include ongoing psychotherapeutic engagement and implementation of psychopharmacologic considerations.

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Given the ongoing disaster climate, we encourage all of AACAP’s membership to better acquaint itself with the Disaster Resource Center and encourage local involvement with disaster relief organizations, such as the American Red Cross and the Medical Reserve Corps. The National Child Traumatic Stress
Network can also be a great resource for providers and families, disseminating reliable information for families and kids. They have also developed a modular approach for Psychological First Aid training that is available for providers on their site. Stay tuned for upcoming collaborative efforts coordinated between the Disaster and Trauma Issues Committee and regional organizations to foster better local and national planning around disaster response.

For more information, reach out to the committee co-chairs, Steven Berkowitz, MD, at berkowsjb@gmail.com, and Linda Chokroverty, MD, at chocolate-birdie@live.com.

References

Dr. Ignaszewski is a Chief Fellow in child and adolescent psychiatry at Boston Children’s Hospital. Her interest in the far-reaching impact of trauma on development resulted in becoming the member-in-training to AACAP’s Disaster and Trauma Issues Committee. She will be pursuing additional training in addiction psychiatry at University of California, San Francisco in 2019, and applying diagnosis and treatment through a trauma-informed lens. She may be reached at martha.j.ignaszewski@gmail.com.
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Earn one year’s worth of both CME and self-assessment credit from one ABPN-approved source. Learn from approximately 35 journal articles, chosen by the Lifelong Learning Committee, on important topics and the latest research.
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Journal CME — (FREE) Up to 1 CME credit per article per month
On Demand: Douglas B. Hansen, MD, Annual Review Course
— Up to 15 CME credits

Questions?
Contact us at cme@aacap.org.
The Assembly Catchers in the Rye Awards are AACAP’s most prestigious awards that recognize an AACAP member, an AACAP component, and a regional organization of the AACAP Assembly for outstanding advocacy efforts. In terms of the award:

Advocacy is any activity done by an individual AACAP member, an AACAP component, or an AACAP regional organization on behalf of children and adolescents with mental health problems or for prevention efforts for children and adolescents at risk that directly benefits them or their families. For example, advocacy could include organizing mental health services for an underserved population, advocating for children and families politically, or enhancing the efforts of child and adolescent psychiatrists to provide high quality mental health services. This includes activities through the American Academy of Child and Adolescent Psychiatry.

AACAP recognizes advocacy in three categories:

- **Individual** that is an AACAP member who advocates for children
- **AACAP Component** (committee or task force) that best advocates for children
- **Regional Organization** of the AACAP Assembly whose activities best highlight the contributions of regional organizations on behalf of children.

Nominations should include a brief paragraph describing the nominee’s advocacy work (only one submission per person for each category).

Awards will be presented at the Assembly’s fall meeting during AACAP’s Annual Meeting in Chicago, IL, October 2019. Please forward your nominations to:

Reina Hamayama, Executive Office Coordinator
AACAP
3615 Wisconsin Avenue NW
Washington, DC 20016
or email to rhamayama@aacaop.org

Nominations due by June 27, 2019
Notes from the 2018 Interim Meeting of the AMA House of Delegates

AACAP’s delegation for the 2018 Interim Meeting of the American Medical Association (AMA) included our delegates to the AMA House of Delegates (Louis Kraus, MD, and David Fassler, MD), our delegate to the AMA Young Physicians Section (Soo Lee, MD), and our delegate to the AMA Resident and Fellows Section (Bud Vana, MD). The delegation was supported by Ronald Szabat, JD, LLM, AACAP’s Director of Government Affairs and Clinical Practice.

The House of Delegates considered over 100 resolutions and reports at this meeting. While providing input and feedback on numerous issues, AACAP focused on specific resolutions dealing with children and guns, violence prevention, and the separation of migrant children from their parents. With testimony from AACAP, the AMA agreed to adopt a policy calling for a background check system for the purchase of firearms, a ban on 3-D printed firearms, and support for “gun violence restraining orders” for people arrested or convicted of domestic violence or stalking.

AACAP delegates also testified on the mental health effects of separating migrant children from their parents and provided the recent Policy Statement on Separating Immigrant Children from Their Families as a potential template for the AMA. AACAP’s position was supported by numerous colleagues, including notable testimony from the President of the American Academy of Pediatrics (AAP), Colleen Kraft, MD. As a result of these collective efforts, the AMA agreed to: strengthen its opposition to policies separating migrant children from their families, as well as any efforts to end or weaken the 1997 Flores agreement which limits the length of time and conditions under which the U.S. government can detain immigrant children.

Commenting on the new policy, Dr. William E. Kobler, a member of the AMA Board of Trustees, noted “the AMA supports the humane treatment of all undocumented children, and advocates for regular, unannounced auditing of the medical conditions and services provided at all detention facilities. These audits should be conducted by independent experts in the care of vulnerable children.”

During the meeting, the delegation had the opportunity to meet with colleagues from the AAP and with members of the Neuroscience Caucus (previously known as “the Brain Trust”). We also participated in the Psychiatric Section Council and Caucus meetings, as well as a meeting for representatives of all specialty societies.

The delegation also attended a reception in appreciation of Carolyn Rabinowitz, MD, a child and adolescent psychiatrist, who recently stepped down as Chair of the Psychiatry Section Council.

Looking forward to the Annual Meeting in June, the delegation is particularly excited to celebrate the inauguration of Patrice Harris, MD, a child and adolescent psychiatrist from Atlanta, Georgia, as the 174th President of the AMA. Dr. Harris will be the first child and adolescent psychiatrist to serve in this position.

Dr. Fassler is the clinical director of Otter Creek Associates, a multidisciplinary group practice based in Burlington, Vermont. He is also a Clinical Professor of Psychiatry at the Larner College of Medicine at the University of Vermont. He may be reached at dfasslervt@gmail.com.

Dr. Kraus is the Woman’s Board Professor and Chief of Child and Adolescent Psychiatry and Director of Forensic Psychiatry at Rush University Medical Center. He is the Founding Director of the Autism Assessment Research Treatment Services (AARTS) Center at Rush. He is the Medical Director of the Chicago Easter Seals schools as well as the Psychiatric Director of the Sonia Shankman Orthogenic School. He is prior Chair of AACAP’s Assembly as well as AACAP Delegate to the AMA. He was prior Chair of the AMA Council of Science and Public Health. He may be reached at Louis_Kraus@rush.edu.

Dr. Vana will complete his Triple Board (General Pediatrics, General Psychiatry, Child Psychiatry) Training at Brown University in June 2019. He will be working with the Lummi Nation Native American Tribe at their Tribal Health Center in Bellingham, Washington, as a pediatrician, adult psychiatrist, and child psychiatrist starting in August. He is interested in expanding the child psychiatry workforce and improving children’s access to quality mental healthcare. He may be reached at bud.vana@gmail.com.

Dr. Lee is an adult, child, and adolescent psychiatrist at the AARTS Center at Rush. Dr. Lee’s interests are in clinical work, clinical drug trials, and access to care for individuals with autism spectrum disorder. She may be reached at soojlee@gmail.com.

Ronald Szabat, JD, LLM, is Director of Government Affairs & Clinical Practice. He may be reached at rszabat@aacap.org.
Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award Recap

ACAP’s Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award was established this past year with a generous donation from Ms. Lisa Yang that honored Marilyn B. Benoit, MD, a former AACAP President and tireless advocate for youth involved in the child welfare system. The award provides a unique mentorship experience for residents, child fellows, or early-career child psychiatrists during a formative time in their career development to further interests in the fields of child welfare and child maltreatment.

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“LBGTQ youth in child welfare experience another layer of vulnerability that requires specialized attention and care: they are at high risk for complex trauma related to the neglect and abuse that brought many of them into foster care, coupled with the high rate of bullying and violence they experience as a sexual minority.”

As the inaugural recipient of the award, I was fortunate to team with Christopher Bellonci, MD, Chief Medical Officer at The Judge Baker Clinic in Boston, and focus on the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth in the Massachusetts (MA) child welfare system, the Department of Children and Families (DCF). Children and adolescents who identify as LGBTQ face unique developmental challenges associated with stigma and prejudice that place them at increased risk for mental health disorders. Research has shown that LBGTQ youth are over-represented in foster care, more likely to reside in a group placement and to experience multiple placement disruptions, and to have increased challenges reaching permanency. LBGTQ youth in child welfare experience another layer of vulnerability that requires specialized attention and care: they are at high risk for complex trauma related to the neglect and abuse that brought many of them into foster care, coupled with the high rate of bullying and violence they experience as a sexual minority. As guardians of these vulnerable children and adolescents, state child welfare agencies must ensure they are placed in environments that protect, nurture, and affirm them, decreasing the risk for continued discrimination and harm.

The award allowed a project called “Reaching the Rainbow: Promoting Best Practices in Mental Health Care for Child Welfare Involved LBGTQ Youth” to provide a structured mentorship opportunity as well as financial support. It offered a platform to begin important advances in caring for LBGTQ youth focusing particularly on transgender and gender non-conforming (TG/GNC) youth in state custody.

One of the first key outcomes of this project was defining and fully understanding the complex factors leading to some of the more pressing issues within the LGBTQ population in MA state custody. These transgender and gender non-conforming youth must access appropriate medical interventions that place them at risk for both under- and over-use. MA has experienced an upsurge in clinics providing medical interventions (hormone-blocking and hormone-affirming agents) to children and adolescents affirming TG/GNC. Many of these clinics use an informed consent approach to start a medical intervention yet do little in the way of reviewing these youth’s mental health challenges. They also leave the risk/benefit decision-making to the parent or legal guardian. Many youth in the child welfare system have experienced chronic trauma and struggle with mental health disorders; because the more intensive mental health supports that this special population requires are ignored, they are at risk for over-using medical interventions. But at the same time, TG/GNC youth who have had appropriate mental health review from multiple providers before medical intervention have ended up in a state judicial consent process that creates a barrier to timely and appropriate treatment. Understanding these challenges made it clear that there was a need to have a protocol in place for TG/GNC youth in state custody seeking medical interventions.

Developing a draft protocol took multiple steps. First, the collaboration with Dr. Bellonci helped guide a literature review which highlighted a current area of need around mental health protocols. While the TG/GNC guidelines do emphasize the importance of mental health evaluations and considerations, they do not outline specific recommendations regarding time in treatment, considerations of a second opinion, and the examiner’s level of expertise. Furthermore, the literature review found limited action by other state child welfare agencies to address this issue. These limitations led to a strong collaboration with a community partner and one of the first gender clinics in the country to better define specific recommendations around a mental health protocol. The continued on page 86
Gender Management Services (GeMS) clinic at Boston Children’s Hospital provides integrated mental health evaluation to all youth undergoing assessment and treatment with hormone-blocking/affirming agents. Utilizing the GeMS mental health protocol for treatment coupled with established guidelines for care of TG/GNC, the protocol for youth in state custody seeking medical intervention was developed.

The award also provided key support for the collaboration with the GeMS clinic to develop and provide training on the specialized needs of TG/GNC youth to targeted MA state child welfare regional nurses, mental health specialists, and medical social workers who provide support for complex medical and mental health cases. The educational component of this award has been crucial in establishing an informed community of specialists within DCF who can help consult to the field around the specific needs of the TG/GNC population.

The award, combined with mentorship from Dr. Bellonci, has provided a foundation of knowledge and guidance to facilitate change within a complex system of care that will have lasting effects, impacting some of the state’s most vulnerable children. As one of the first states to look closely at the needs of TG/GNC youth, this hormone consent protocol draft may be used as a guide for other states interested in assuring appropriate care for some of the most vulnerable youth in state custody. This award helped to create bridges among community providers as well as internally within the state child welfare agency, opening a pathway for future collaboration to improve the mental health care for LGBTQ youth in state custody.

References
3. “The World Professional Association for Transgender Health: Standards of Care for Health of Transsexual, Transgender, & Gender Nonconforming People” 7th Version. www.wpath.org
4. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents Jason Rafferty, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness Pediatrics Oct 2018, 142 (4) e20182162; DOI: 10.1542/peds.2018-2162

Dr. Morgan completed her training in child psychiatry at UMass Medical School in Worcester, MA, where she now holds a faculty position as an Assistant Professor of Psychiatry at UMass Medical School. As an early-career psychiatrist, Dr. Morgan has devoted her clinical work to improving the mental health care for youth in the child welfare system. She is the Consultant Child Psychiatrist to Office of the Medical Director at the Department of Children & Families in Massachusetts. She also is the lead child psychiatrist for an integrated foster care clinic at UMass called FaCES Safe & Sound clinic. Dr. Morgan has been a member of the Adoption and Foster Care Committee since 2012, and this year has stepped into a leadership role as co-chair of the committee. She may be reached at wynne.morgan@umassmemorial.org.

Dr. Bellonci is Vice President for Policy and Practice/Chief Medical Officer at Judge Baker Children’s Center. Dr. Bellonci is a member of AACAP’s Committees on Quality Issues and Community-Based Systems of Care. He is the Medical Director of the National Technical Assistance Network for Children’s Behavioral Health in support of the Substance Abuse and Mental Health Administration’s (SAMHSA) Systems of Care initiative. Dr. Bellonci is a founding member of SAMHSA’s Building Bridges Initiative and LGBTQI2-S National Workgroup. In these roles and through his academic and clinical work, Dr. Bellonci is a recognized leader in advancing evidence-based and best practices in addressing the needs of youth with behavioral health needs throughout the service array. He has expertise and experience in promoting services and supports for youth who identify as lesbian, gay, bisexual and transgender. He may be reached at cbellonci@ jbcc.harvard.edu.

Being an AACAP Owl

AACAP Members qualify as Life Members when their age and membership years total 101, with a minimum age of 65 and continuous membership.

Benefits: Annual AACAP Membership Dues are optional. A voluntary JAACAP subscription is available for $60.

Fact: Over 1,080 of AACAP’s members are Life Members.

Are you a Life Member who would like to be more involved in Life Member activities? Contact AACAP’s Development Department at 202.966.7300, ext. 140.
Psychodynamic Faculty Training and Mentorship Initiative

Rachel Ritvo, MD

AACAP’s Psychodynamic Faculty Training and Mentorship Initiative is a program dedicated to providing faculty development for academic child and adolescent psychiatrists teaching psychodynamics. It aims to maintain and enhance the capacity of AACAP members to use psychodynamic theories and techniques as part of the treatment of children or adolescents with mental, emotional, or developmental difficulties. Rachel Ritvo, MD, and Martin Drell, MD, co-chair the initiative. A. Lee Lewis, MD, has served as liaison from the Training and Education Committee, and Cecil Webster, MD, has served as liaison from the Psychotherapy Committee, from which the initiative emerged. Out of 16 applications in the initiative’s first year, six mentees were selected to participate and were assigned a mentor: Dalia Balsamo, MD (UCRiverside), Sindhu Idicula, MD (Baylor), Suzie Nelson, MD (Wright State University), Magdalena Romanowicz, MD (Mayo Clinic), Ravi Shankar, MD (UMissouri-Colombia), and Michael Shapiro, MD (UFlorida).

The initiative is indebted to its volunteer mentors—Sergio Delgado, MD, Mary Lynn Dell, MD, Timothy Dugan, MD, David Kaye, MD, Sandra Sesson, MD, and Ayame Takahashi, MD—who are giving their time and knowledge to make this program possible.

The program got off to a good start at AACAP’s 65th Annual Meeting in Seattle. On the Monday before the Annual Meeting, the initiative ran a planning day at which each mentee met with his/her assigned mentor to review the difficulties facing their training program and to flesh out a mentored project that would begin to address one or more of these difficulties. The day was planned so that the projects could be presented and discussed both in a small group and in a plenary discussion.

Many programs rely on psychologists or social workers to teach psychodynamics. While we appreciate the knowledge and skills these clinicians impart to our trainees, we feel strongly that our trainees will respect psychodynamic approaches in their work with children and adolescents more if it is taught and modelled by child and adolescent psychiatrists.

“We need to provide a variety of resources through AACAP’s website or other media from which faculty can pick and choose what fits.”

The mentoring program leads to careful observation of the difficulties that have hampered the teaching of psychodynamics in each participating program. Although a lack of appropriate patients or issues over reimbursement are among the roadblocks cited most frequently, we are finding hidden issues to psychodynamic training, such as a program’s need to deploy their most qualified child and adolescent faculty to teach the general psychiatry residents. Tension can also arise between thinking of psychodynamics as simply a therapy and losing sight of its value in understanding development and as a general psychology. The initiative’s larger goal is to ultimately share its observations with and offer solutions to the greater AACAP community. We are already aware of how diverse our training programs are in terms of size, location, and resources. We need to provide a variety of resources through AACAP’s website or other media from which faculty can pick and choose what fits.

Convening a group of dedicated educators from across the United States and listening to their specific goals, strengths, weaknesses, opportunities, and threats to teaching psychodynamic psychiatry has sensitized all of us to the challenges we face in reaching this initiative’s goals. The lessons we have already learned from the first year of the initiative will assist us in improving the effectiveness of AACAP’s Psychodynamic Faculty Training and Mentorship Initiative as we move into year two. In addition, we plan to share these lessons with AACAP’s Psychotherapy Committee to assist its liaisons and efforts to improve psychotherapy training in general.

Those interested in participating in year two of this initiative are encouraged to apply. Members who have a strong background in psychodynamics, are actively involved in training CAP fellows, and would like to mentor a younger colleague are encouraged to reach out as well. Visit www.aacap.org/PFTMI, or contact training@aacap.org with questions. AACAP’s Psychodynamic Faculty Training and Mentorship Initiative is supported by The Samuel and Lucille Ritvo Charitable Fund.

Dr. Ritvo is assistant clinical professor of Psychiatry and Behavioral Sciences at the George Washington University School of Medicine and Health Sciences, is on the faculty of the Baltimore-Washington Psychoanalytic Institute and Children’s National Medical Center, and has a private practice in Kensington, MD. She may be reached at rzritvomd@gmail.com.
Enriching Your Institution’s Psychotherapy Training

AACAP’s Psychodynamic Faculty Training & Mentorship Initiative is designed to support and advance psychotherapy training in ACGME accredited, child and adolescent psychiatry programs. The program provides faculty recipients with the opportunity to:

LEARN best practices and skills in the specialty.
DEVELOP and implement training plans based on program needs.
COLLABORATE with leaders in teaching psychodynamic psychotherapy.

Benefits

- Opportunity to attend a one-day training session and networking events at AACAP’s 66th Annual Meeting (October 14-19, 2019) in Chicago, Illinois.
- $450 in travel support to offset expenses for attending the training session.
- Engage with a community of mentors.

Eligibility

- MD, DO or equivalent degree
- Teach in an ACGME accredited child and adolescent psychiatry, triple board, or post pediatric portal training program
- AACAP Member or have a membership application pending at the time of submission

Apply

Download and complete the application form at www.aacap.org/PFTMI
Submit the following application materials via email to training@aacap.org
- Curriculum vitae
- Letter of endorsement from the Residency Program Director/Training Director (showing support for the enhancement of psychodynamic psychiatry in your training program)
- Two additional letters of recommendation (optional)

LEARN MORE!

For application information contact:
AACAP’s Research, Grants and Workforce Department
Visit: https://www.aacap.org/PFTMI
Email: training@aacap.org
Applications are open now through May 1st 2019
Earn CME from anywhere, at anytime!

Pathways is AACAP’s new online learning portal, which allows you to access top rated courses to earn CME credit on your schedule. Pathways serves as your continuing medical education home, giving you access to a variety of online courses and activities, including:

✦ Clinical Essentials on Substance Use Disorder
✦ Free JAACAP CME
✦ Lifelong Learning Module 15
✦ On Demand Douglas B. Hansen, MD, 43rd Annual Review Course

In addition to these great online activities, Pathways transcript feature allows you to track your CME certificates from AACAP and other organizations in one place. To learn more about these exciting CME opportunities, visit www.aacap.org/onlinecme.

Share Your Photo Talents With AACAP News

Members are invited to submit up to two photographs every two months for consideration. We look for pictures—paintings included—that tell a story about children, family, school, or childhood situation. Landscape-oriented photos (horizontal) are far easier to use than portrait (vertical) ones. Some photos that are not selected for the cover are used to illustrate articles in the News. We would love to do this more often rather than using stock images. Others are published freestanding as member’s artistic work.

We can use a lot more terrific images by AACAP members so please do not be shy; submit your wonderful photos or images of your paintings. We would love to see your work in the News.

If you would like your photo(s) considered, please send a high-resolution version directly via email to communications@aacap.org. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
Honor Your Mentor

Each year in the March/April issue of AACAP News, we take the time to honor our mentors and say thank you to those who have made a significant difference in our professional and personal lives.

Balkozar Adam, MD
Submitted by Rasha El Kady, MD

I have come to know Dr. Adam during my first year of residency. She was a role model in patient care, professionalism, and leadership. Dr. Adam served as an excellent teacher, involving me in many research projects and always encouraging me. I moved to the United States when I started my residency, which was one of the biggest challenges of my life. Dr. Adam helped me with the acculturation process. Dr. Adam spent all this time and effort helping me, becoming my teacher and mentor, and she expected nothing in return. I model that example with my trainees.

Basil Bernstein, MD
Submitted by Cheryl Green, MD

Dr. Basil Bernstein, UCLA-trained, and for many years a fixture of psychiatry in Southern California, was my mentor during my first year of work. He taught me to think very comprehensively not only about children, but also about my career. A true friend, at one point he gave me advice that might have gone against his own interests, because he felt that it was in my best interests. Dr. Bernstein was and is utterly brilliant, kind, and humane. My sincere wish for him is actually his own blessing: “May the sun always be shining... wherever you are.”

Gabrielle A. Carlson, MD
Submitted by Sandra Hershberg, MD

When I was a child psychiatry fellow at UCLA, Dr. Gaye Carlson was the Acting Head of Child Psychiatry. She took on a huge responsibility after the Chair, Denny Cantwell, became ill, teaching much of the curriculum, an unexpected task, and being responsible for our fellowship group. Further, Gaye mentored me in writing my first paper, which I published and presented, a task my husband, a physician researcher, encouraged me to take on, especially since it felt outside of my experience and comfort. Using a portion of her raw research data on anxiety and depression in children, I interpreted the data, in conversation with her, and in the context of known theory and practice. That experience enlarged my self-concept in seeing myself as an active contributor to scholarly work in the field, one which I have continued as a contributor in psychoanalytic writing and as director of a psychoanalytic institute. As a woman, it was particularly valuable to work with a generative mentor with whom I could identify.

Kathryn Cullen, MD
Submitted by Rana Elmaghraby, MD

Dr. Kathryn Cullen is a wonderful mentor. I have worked with her for over a year now on various scholarly work from posters to opinion pieces. She groomed me to be a sound professional and researcher. Dr. Cullen showed me how interesting and enjoyable research can be. She welcomes my questions with an open heart and is willing to spend time out of her busy schedule to guide me. She has everything that makes her a great mentor. She was one of the mentors that sparked my interest in child and adolescent psychiatry.
John H. Davis, MD
Submitted by Douglas A. Kramer, MD, MS

John H. Davis, MD, a.k.a., “Captain Hawkeye Pierce,” Chief of Surgery at the University of Vermont, taught me to be a physician. During my Straight Surgical Internship (1971-72), I often scrubbed with Dr. Davis, talking not just about the case, but also about what it means to be a physician. Once he challenged me to do a below-knee amputation in less than ten minutes, the lesson being that speed and efficiency saves lives. The most important lesson from Dr. Davis was humility, and that the real hero in healing the patient is not the surgeon, but the resiliency and healing capacity of the human organism.

Like all great mentors, he treated me as a peer. Only five years ago, with the help of James J. Hudziak, MD, did I learn that Dr. Davis was the primary model for “Hawkeye Pierce” in the book and television series, “M.A.S.H.” Now I fully understand why we did the procedure in less than ten minutes. Following my internship, I joined the U.S. Navy as a Flight Surgeon, and served on a base in the Aleutian Islands for two years.

Sandra DeJong, MD, and Cindy Tellingator
Submitted by Meg Benningfield, MD

I’m so grateful for the mentorship I’ve received from so many in the AACAP community—it’s hard to choose just one person. Sandra Dejong and Cindy Tellingator served as program directors in my training at Cambridge, and I would not be where I am today without their love, support, guidance, wisdom, practical advice, and dedication to their work and to me as a trainee and beyond. Both have modeled how to fit meaningful work into otherwise full lives. Thank you both for being who you are!

Antoine Douaihy, MD
Submitted by Gil Hofman, MD, PhD

“In a real sense all life is interrelated. All [people] are caught in an inescapable network of mutuality, tied in a single garment of destiny.” MLK, Jr.

Dr. Douaihy’s mentorship on the dual-diagnosis inpatient unit was a transformative experience. He modeled channeling empathy into action daily using motivational interviewing; I am grateful to call Antoine my mentor, role model, and friend. He gracefully combines detailed instruction with a broad conceptual framework that fosters meaning in each encounter. Fundamentally, Antoine confirms we are human first, mutually interconnected “in a single garment of destiny.”

Jackie Etemad, MD
Submitted by Virginia Q. Anthony

I write to acknowledge a hero, Dr. Jackie Etemad, a child psychiatrist from San Francisco. In my early days with AACAP, Jackie was an Assembly delegate and served on Council several times. She was thoughtful and could be counted on. One of her passions was advocacy, and although she chaired a committee to outline possibilities, she was the prime author and mover. Our Catchers in the Rye Awards that recognize and encourage leadership by individuals, committees, and regional councils are one of the results of her leadership. Thank you, Jackie, for serving as a role model for so many and your passion.
Elise Fallucco, MD  
Submitted by Kitty Leung, MD

Dr. Elise Fallucco has been an instrumental mentor and role model to me. She has helped me improve my confidence, as well as taught me to not limit myself and pursue my dreams. I have been able to celebrate my success and achievements, as well as share my setbacks and failures with her. She provides honest feedback, positive encouragement, and has been a very good advocate for me. Working with Dr. Fallucco has been an invaluable experience for me in my academics, research, career path, and personal growth, and I am truly grateful!

Maureen Gordon, MD  
Submitted by Sandra Hershberg, MD

Dr. Maureen Gordon was a stand-out as a teacher and supervisor at UCLA. She taught us how young children develop and how to understand their world. She enlivened theory with direct observations and turned us into clinician researchers by encouraging us to observe children outside the confines of the consultation room, with their parents in the waiting room and at nursery school, turning our observations into theories and testing our theories against our observations. In supervising a challenging case of gender dysphoria, she helped me deconstruct the family relationships and intrapsychic dynamics in a way that made psychological sense and advanced the therapeutic action. She would observe me via a one-way mirror, in addition to merely supervising me with process notes. Through her insight and, crucially, her emotional availability, Dr. Gordon fueled my empathy and reflective capacity, expanding my confidence and sense of agency as a child psychiatrist.

James Harris, MD, and Cathy DeAngelis, MD, MPH  
Submitted by Maryland Pao, MD

I just want to give a shout out to my academic parents, Drs. Jim Harris and Cathy DeAngelis. They took an idealistic third year medical student who wanted to be a pediatric consultation liaison psychiatrist and created a special pathway at Johns Hopkins that allowed me to be triple boarded and led me to eventually be grandfathered into the CL boards. Now I have been the Chief of the Consultation Liaison Service at the NIH Clinical Research Center for the past decade. A few other cool jobs happened along the way. Thanks for the great mentoring, Cathy and Jim!

Suma Jacob, MD, PhD  
Submitted by Rana Elmaghraby, MD

Dr. Suma Jacob has everything that qualifies her not only a great but a phenomenal mentor. She is so humble and professional that I always aspire to reach her level one day. She helped me navigate my path and determine how to narrow my research interest. In addition, she makes it seem possible to be able to integrate work-life balance and not worry about jeopardizing one or the other. She has involved me in her community outreach work to increase awareness of managing ASD. I am honored to call her my mentor and grateful for the opportunity to work with her.
Sheryl Kataoka, MD
Submitted by Misty Richards, MD, MS

Dr. Sheryl Kataoka cares deeply for those around her. She leads by example, models integrity in her everyday actions, and reminds us all that being a kind, good human being matters most. Despite being one of the most accomplished faculty members in our child division at UCLA, she carries herself with humility and grace. She wants the best for those around her and, as a result, cultivates a wonderful environment for her colleagues/mentees to thrive.

On a personal level, Sheryl has been my mentor for close to four years. She has shepherded me through my transition from child fellow to junior faculty at UCLA, and I am so grateful for her honesty, vision, and belief in me through all the twists and turns. She reminds me to always do what is right, to try to be kinder and wiser every day, and that there is incredible value in giving back to the community and those around you. I am grateful to Sheryl for not only being one of the best mentors, but for being a trusted, invaluable friend.

John Kemph, MD
Submitted by Stewart Teal, MD

My first rotation in my psychiatric training was at the VA Hospital in Ann Arbor Michigan. My supervisor was Dr. John Kemph. It is not clear to me even now why John, a child psychiatry professor, was assigned to the VA. As I struggled with many chronically ill patients one day in supervision, he looked me in the eye and stated flatly, “you should be a child psychiatrist.” Later in my training I negotiated a six month rotation at Children’s Psychiatry Hospital, and it was clear to me he was absolutely correct. My training was split due to the Vietnam War. After adult training I owed the government two years, but I was fortunate to be stationed at an air force base with a child, family clinic. They put me in charge because of my one year of child-adolescent training. When I returned to Michigan for my last year of child, I’ll never forget John’s huge grin as he handed me my diploma.

Jung Kim, MD
Submitted by Richard Seeber

Dr. Kim sets a standard for mentorship of medical students. My time on his service was an experience in personal and professional growth, in which he gave me the opportunity to be fully engaged in the psychiatric care of children. Beyond being a paragon of compassionate patient care, he invests significant time in students – he went out of his way to get to know me and offered his mentorship on research projects I found exciting. His investment helped spark my interest in psychiatry and continues to stoke the fire; I hope to emulate his example in my practice one day.

Wun Jung Kim, MD, MPH
Submitted by Jasmin Lagman, MD

A big thank you to my CAP fellowship program director at Rutgers RWJMS in Piscataway, NJ, Dr. Wun Jung Kim. He turned my weaknesses into strengths, opened opportunities, and made fellowship less stressful and fun!

“He is so cool!” This is the reaction I had on my first meeting with Dr. Kim during my fellowship interview. Having him as the program director was one of the reasons why I chose Rutgers RWJMS for my child fellowship. There was something in him that made me at ease and comfortable. He has a unique sense of humor and a contagious laugh. He is not only personable, but a respectable person in the field, being the previous AACAP News editor and co-chair of AACAP’s International Relations Committee, among others. He is professional and seemed to navigate things with such ease. He’s able to make difficult patients talk and always has a smile on his face, even in stressful situations. I loved seeing and discussing patients with him. He’s one of those persons who has answers to almost any question you ask. I used to tell him how I wish I can have him wherever I practice. Life would have been so much easier.
His door was always open. He never turned away any trainee who needed to talk to him, whether it’s work-related or personal matters. I have seen how he protected and supported his trainees but also set the limits in a fair and professional way. Up to this day, when I am already working as an inpatient psychiatrist, I still reach out to him to seek for advice and guidance. His responses always gave me a smile and feelings of reassurance. He has been treating me with no less than kindness and respect. To Dr. Kim who has provided me with continued support and who believed in me as a woman, an IMG, and as a child psychiatrist, THANK YOU for bringing out the best in me. I am forever grateful.

William Klykylo, MD
Submitted by Cheryl Green, MD

A self-proclaimed PGY-40, Dr. William Klykylo was the main person who trained me, and nearly all of my other trainers, as well. Dr. Klykylo always had some truth upon which to enthusiastically expound, whether the vagaries of the healthcare system in America, the difference between boundary violations and boundary crossings, the joys of ham radio, or the utility of the Oxford comma. He taught me so much just by being who he was and is. I will never forget his brilliance, his gravitas, his wisdom, his humor, his kindliness, nor his warmly humane spirit.

Jesus-Martin Maldonado-Duran, MD
Submitted by Stephen R. Mandler, DO

Jesus-Martin Maldonado-Duran, MD, currently Professor at University of Missouri, Kansas City, was my mentor at the Menninger Clinic in the late 90s. He introduced me to the world of infant mental health and supported my interest in early intervention and prevention. He took me on home visits and WIC clinics, and he helped me as I learned to work in the NICU. Still, a large number of the patients I see are infants, toddlers, and their families. I will be forever grateful for his impact on me and the way I think.

Andrés Martin, MD, MPH
Submitted by Jack Turban, MD, MHS

I can never thank Dr. Martin enough for the impact he has had on my life. With his unique combination of brilliance, humor, and compassion, he helped me to see how meaningful a career in child psychiatry could be. His mentorship during my time on the inpatient child psychiatry unit at the Yale Child Study Center ignited my passion for a field that has become so important to me. Dr. Martin’s mentorship also goes far beyond the Child Study Center. I truly feel that he has become a family member to me. I will never forget him inviting me to his home when I was preparing my thesis work. Over coffee in his living room, we went over my presentation, with even his children giving feedback on my talk. Though I’m now away in Boston, he’s always there supporting me through difficult times, challenging me to push myself further in research and journalism, and guiding me through the great world of child psychiatry. Gracias, Dr. Martin!
Karen Martínez, MD, MSc  
Submitted by Katyna Rosario, MD

Karen is simply hands-on! She makes things easier. I am almost 40, and I still look up to her and see the person that I want to be when I grow older. She has been my mentor through medical school, research, meetings, residency, fellowship, and life. She has a simplified view of the world no matter how complex it gets. In rough times she is the best shoulder to lean on. One of her favorites is: “What’s the worst that could happen?” I’m grateful for her legacy, and I’m honored to call her not only my mentor but also my friend.

Ayesha Mian, MD  
Submitted by Aisha Sanober, MBBS, FCPS

I had not truly imbibed the meaning of mentorship until I met Dr. Mian. Over time, her input in all things, small and large, has greatly inspired me. She has a skill for knowing when to challenge my thought process and to help repackage my many cluttered ideas into a coherent proposition.

Dr. Mian has taught me to look every challenge in the eye and face it. Her visionary and value-centered guidance challenged me to think beyond my clinical work and take responsibility for the bigger picture. She truly believed in my potential, which made all the difference in my ability to ultimately reach where I am today.

Oluwayemi Cecilia Ogun, MD  
Submitted by Grace Ijarogbe, MD

I work as a psychiatrist specialized in children’s mental health in the largest facility in Nigeria.

About 19 years ago, there was no child and adolescent psychiatric facility in Nigeria. Pockets of practices existed which were hardly ever found by the consumers. A female psychiatrist began to advocate amidst denials, poor or nonexistent facilities, unavailability of training for such services to be created within the federal neuropsychiatric hospital in Lagos. A lot of resistance met her courageous effort. Eventually, she agreed to start at an ordinary room carved out of a crèche with a nurse and special educator as the sole staff. As a senior staff member then, her contemporaries would never have acceded to the loss of comfort in clinical practice space, but she weathered the storm. She sponsored herself to travel out of the country periodically for training and exposure in child psychiatric practice and tried to co-opt other stakeholders, like the occupational therapist, into practice.

Through continuous hard work and determination, that small CAMH service which started from ground zero has grown through fortuitous circumstances to become the most sought-after child psychiatric center in Nigeria and indeed in West Africa. Now hosted within a donated building, it is comprised of a CAMH-trained multidisciplinary team – three other CAMH trained psychiatrists, including my humble self, occupational therapists, special educators, psychologists, social welfare officers, pharmacists, physiotherapists, EEG technicians, and child minders. The outpatient clinic currently has over 14,000 outpatients registered, and the inpatient facility cannot hold the demand anymore. There is still so much to do, but I stand up at this moment in time to give this ovation to the selfless, determined, courageous woman who birthed it all and continues to serve unsung in the shadows – Dr. Oluwayemi Cecilia Ogun.
Sigita Plioplys, MD  
Submitted by Agnes K. Costello, MD

I had a chance to work closely with Dr. Sigita Plioplys as a child psychiatry fellow at Ann and Robert Lurie Children’s Hospital in Chicago in 2008. At the time, she had just created a multidisciplinary diagnostic clinic for children with comorbid neurological and psychiatric illnesses. My time with her taught me that the most complicated patients are not to be feared, that nonverbal does, in no way, mean non-communicative, and that families of these children can find relief just from having a good formulation of their child’s brain and behavior explained to them. Neurodiversity was still not an official “thing” back then, but looking back, she taught me how to respect and find the positive in even the most “differently wired” brains. This has shaped the way I have practiced to this day, and I am grateful for her influence.

Judith Robinson, MD  
Submitted by Kara Curry, DO

“There are a million different ways to help someone!” This was the hopeful and genuine reassurance offered to me by Dr. Judy Robinson during a moment of worry and self-doubt about whether I was managing a patient’s treatment effectively. Her words mark the openness, flexibility, practicality, and wisdom she demonstrates on a daily basis as she goes about teaching and practicing psychiatry at Tufts Medical Center. She has a diverse background when it comes to clinical experience and teaching, yet her expertise is married with continual curiosity and a humble nature. It is hard to conceive how she seamlessly balances an enormous amount of integrity and knowledge with such a compassionate and encouraging attitude as well, but it is her well-roundedness which leaves her unmatched as a standout physician and mentor.

Jeffrey Rowe, MD  
Submitted by Desiree Shapiro, MD

Dr. Jeffrey Rowe dedicated his career to improving youth and family mental health with local, state, and national reach. Along his journey, he has generously volunteered his time to mentor anyone who wished to learn or grow. Over the years, I have witnessed him teach and lead enthusiastically, dream big, model excellent care, humbly learn, and design innovative programs for our community. As my mentor, he has encouraged my professional and personal growth while honoring my role as a mother. Beyond his vast knowledge and experience, he has a gift of bringing people together, collaborating, and achieving positive change.

Cynthia Santos, MD  
Submitted by R. Dakota Carter, MD

Dr. Cynthia Santos has been an instrumental mentor and has been a source of support during my child fellowship. She is the type of child psychiatrist I aspire to be! Dr. Santos is the epitome of professionalism, clinical excellence, and has been an influential clinical educator throughout my training. I value her motivation to seek out opportunities to improve my clinical background while providing a model to strive for in her delivery of care to her patients and her amazing national work she continues to do to improve our profession, training programs, and lives of our patients.
I would describe Dr. Sengupta as a beautiful person, inside and out, a person of character and integrity, and a fine clinician (the caliber of which I would like to be when I grow up). Dr. Sengupta is the child and adolescent psychiatry fellowship program director at the State University of New York at Buffalo (UB). I am most fortunate to be his mentee. Dr. Sengupta is one the reasons I decided to do my child psychiatry training in Buffalo. I have not for once regretted my decision. Dr. Sengupta has been one of my loudest and effective cheerleaders. He has been very instrumental in my professional and personal growth. I would like to use this platform to say a big thank you to Dr. Sengupta for all he has done and continues to do for me, my colleagues (child psychiatry fellows at UB), and our training program.

Annie Steinberg, MD
Submitted by Uma Nuthi, MD

My words pale in comparison to the utmost respect and admiration I have for Dr. Annie Steinberg, her love, commitment, and dedication to caring for children. In addition to being an excellent clinician, she has taken caring for children to a personal level by adopting and fostering several children in need, while working full time. I had the good fortune of being supervised by Annie during my child psychiatry fellowship at PCGC (1994-1996). Her warm and caring manner put me at ease and made supervision something to look forward to. Her passion for teaching is incredible. When I had expressed an interest in forensic psychiatry fellowship (before University of Pennsylvania started it), she enthusiastically called the renowned forensic psychiatrist Diane Schetky, MD, to inquire about fellowship programs. From watching her, I learned confidence and reaching out to others. Her compassion, sense of humor, and humility are inspiring. I am unsure of any personal reasons for her to learn American Sign Language, but she has done exceptional work with hearing impaired children and their families and is a strong advocate for them. She will always be my role model, as there is always a lot more to do in child psychiatry.

Dorothy Stubbe, MD
Submitted by Shehryar Khan, MD

I want to honor my mentor, Dr. Dorothy Stubbe. She is one of the nicest and sweetest person I have ever met and goes above and beyond to ensure all there is wellness in the training environment. She is always available by phone and will stay till the last leaves their outpatient office. She even volunteered herself to cover an overnight call for a fellow who was going on maternity leave. She creates an atmosphere of open dialogue, discussion and free flowing ideas in an enriching diverse environment. There is no other mentor who is more deserving of this award than Dr. Stubbe.

Agnes Whitaker, MD
Submitted by Nina Tioleco, MD

Agnes Whitaker, MD, has been an amazing mentor. I have an interest in autism and developmental disorders, and Agnes has been influential as I delved into the field. She has been extremely supportive in my professional development and has gone above and beyond to help me reach my goals. Additionally, she is a trusted resource, and I am in constant awe at how much she knows. I would not be the psychiatrist I am today without her wisdom and guidance.
New Research Poster Call for Papers

Deadline: June 4, 2019

AACAP’s 66th Annual Meeting takes place October 14-19, 2019, in Chicago, IL. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry that advance the field and can be used to improve the well-being of children and their families, e.g., clinical treatment, research, training, development, service delivery, administration, translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and suicide and violence prevention. In addition, submissions on depression are encouraged to support AACAP’s current Presidential Initiative.

NEW THIS YEAR: There are two opportunities to orally present your poster in some special sessions. See more details on the Call for Papers page and indicate your interest on step 1 of the form.

Verbal presentation submissions were due February 14 and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by June 4. The online submission site will open early April. All Call for Papers applications must be submitted online at www.aacap.org/AnnualMeeting-2019.

If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

Did you miss this year’s Pediatric Psychopharmacology Update Institute or Douglas B. Hansen, MD, Annual Review Course? Are you looking to learn something new? AACAP has just what you need!

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

Session recordings from this year’s meeting (including PowerPoint slides) are available to purchase individually or as part of a full conference set.

Visit AACAP’s Learning on Demand at aacap.sclivelearningcenter.com for more information and to see free samples of content available.

No CME credit is available with session recordings. Session availability subject to speaker permission.
AACAP’s Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award, made possible by a generous donation from Ms. Lisa Yang, seeks to provide an experiential opportunity to those interested in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention. Ms. Yang’s donation was instrumental in developing AACAP’s Marilyn B. Benoit, MD, Fund.

A total of $8,000 is divided between a maximum of two awardees to facilitate the completion of an individual project lasting 12-16 weeks in which they collaborate with a mentor of their choosing. Eligible applicants must be a child and adolescent psychiatry resident, child and adolescent psychiatry fellow, or early career psychiatrist within seven years of graduating from a fellowship program and have an interest in the field of child welfare, foster care, and/or child maltreatment prevention/intervention. Mentors must have experience in key issues in any of these areas, but they themselves do not need to be child and adolescent psychiatrists by training.

For additional information, please visit: www.aacap.org/CMMA or contact us at clinical@aacap.org.
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The ABPN MOC Part III Pilot Project is now live for eligible participants and AACAP has assembled all 40 of the articles for you in one convenient location at:

www.aacap.org/pilotproject

For questions regarding the Pilot Project, including eligibility, please contact questions@abpn.com.

For questions regarding article access please contact cme@aacap.org.

In Memoriam

William Kirk, MD
Cogan Station, PA
FOR YOUR INFORMATION

Learn more about the products and services AACAP has to offer our members at all career stages! We particularly recommend that training directors make use of this resource as an introductory guide to AACAP for their trainees. Visit www.aacap.org to download the PowerPoint.

Thank you to the Consumer Issues Committee for their work on this useful product!

AACAP Catchers in the Rye Humanitarian Award

Deadline: March 27, 2019

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

The award recipient is recognized for their impact on children’s mental health at AACAP’s 66th Annual Meeting in Chicago, IL, October 14-19, 2019. Recipients are required to attend the awards ceremony at AACAP’s Annual Meeting. Please note:

- Only non-AACAP members are eligible to receive the award
- Only AACAP members may submit nominations
- Nominees from the Chicago, IL, area are encouraged

Please submit the following information with the nomination:

- Name and contact information of nominator, including email, phone number, and mailing address
- Name and contact information of nominee, including email, phone number, and mailing address
- 250-500 word explanation of why the nominee deserves the award
- 2-3 paragraph biography or abridged CV (no more than 4 pages) of the nominee
- If available, supporting information that would be helpful to inform the selection committee, such as a website, book, magazine, or journal profile

All nominations must be submitted to AACAP’s Development Office via email at development@aacap.org. Nominations must be in a PDF or Word document. Please write “AACAP 2019 Humanitarian Award Nomination” in the subject line of the email.

If you have questions about the award or the award process, please contact development@aacap.org.
Staff Recognition

We acknowledge and appreciate that the foundation of our success is built upon the commitment of both members and staff. This is our opportunity to celebrate the efforts, enthusiasm, and longevity of the following AACAP staff:

Danielle Jackson, Office/Operations Specialist, recognized for 15 years of outstanding service to AACAP!
(from left to right) Danielle Jackson, Office/Operations Specialist, Heidi Fordi, Executive Director

Naomi Franklin, Accounts Receivable Specialist, recognized for 16 years of outstanding service to AACAP!
(from left to right) Jacqueline Gosby, Director, Finance, Tiawain Rodgers, Assistant Comptroller, Naomi Franklin, Accounts Receivable Specialist, Heidi Fordi, Executive Director

Nelson Tejada, Membership Coordinator, recognized for 20 Years of outstanding Service to AACAP!
(from left to right) Jaime Owens, Membership & Marketing Manager, Rob Grant, Director, Communications & Member Services, (front) Nelson Tejada, Membership Coordinator, Stefon Valencia, Assistant Director, Member Services, Samantha Phillips, Communications Manager
Welcome New AACAP Members

Oluwemimo Adeyanju, MD, Rochester, MN
Tolulope A. Alugo, MD, FRCP, Saint John, NB
Andrew Amicarelli, Orlando, FL
Claudia Antila, MD, Sorocaba, Sao Paulo, Brazil
Erica Michelle Arrington, MD, Milwaukee, WI
Sajid Arshad, MD, East Brunswick, NJ
Isaac Baldwin, Kansas City, KS
Daniel Bigman, MD, Philadelphia, PA
Laura Black, MD, Seattle, WA
Carla Black, MD, Metairie, LA
Jennifer Boatwright, Manchester, GA
Yuri Brito, Bellmore, NY
Taylor Burns, MD, Schaumburg, IL
Erica Campbell, Sebring, FL
Cesar Cardenas, Jr., MD, Brandon, MS
Esteban Cardonne, MD, Hialeah, FL
Stephen Cheek, MD, Atlanta, GA
Grace Cheney, MD, Tampa, FL
Patrick W. Conway, DO, MD, Louisville, KY
Sondra Corgan, MD, Glen Oaks, NY
Josiah Cox, MD, New Orleans, LA
Blair Curtis Davison, MD, Missoula, MT
Stephen Deci, MD, Morgantown, WV
Rashmi Deshmukh, MD, Fremont, CA
Christy Duan, MD, Astoria, NY
Daphna Finn, MD, San Diego, CA
Erlin Fulchiero, MD, Cleveland, OH
Shan Gao, MD, Pittsburgh, PA
Spencer Gardner, Columbus, OH
Annesly Gates, MD, New York, NY
Paulo Marcelo Gondim Sales, MD, Brooklyn, NY
Rohan Gopalani, MD, Merion Station, PA
Howard Gottlieb, MD, Kingston, NY
Marcel Green, MD, Astoria, NY
Christine Grosso, Melville, NY
Victor George Grosu, MD, Manalapan, NJ
Christina Guest, MD, Thousand Oaks, CA
Victor Guzman, MD, Hialeah, FL
Stephanie Han, MD, Fresno, CA
Jamie L. Hanna, MD, New Orleans, LA
Elizabeth Hoy, MD, Miami Beach, FL
Jennifer Inbarasu, MD, Rochester, MN
Christopher Ivany, MD, Vienna, VA
Veeraraghavan Iyer, MD, Longmeadow, MA
Anik Jhonsa, MD, Mooresown, NJ
Isaac Johnson, New Haven, CT
Cleverson H. Kaio, MSc, Curitiba-PR
SivabalaI Kallamurthy, MD, Hartford, CT
Michael Kelly, MD, Redwood City, CA
Eslam Kersha, West Bloomfield, MI
Nida Khawaja, MD, Flowood, MS
Danica Kozek, MD, Greenville, SC
Hephshibah Loeb, MD, Philadelphia, PA
Pankaj Manocha, MD, Bronx, NY
Brooke Mastroianni, MD, Suamico, WI
Andrea Mobilio, MD, Ann Arbor, MI
Smita N. Naidoo, MD, MPH, Vancouver, BC
Brittany Napier, MD, Saint Paul, MN
Stephanie Ng, MD, New Haven, CT
Halsey Niles, New Haven, CT
Kyu Young Oh, New York, NY
Jennifer Onaga, Henderson, NV
Nihraka Padala, Avenel, NJ
Nina Paddu, Syosset, NY
Nikhil Patel, MD, Cambridge, MA
Nicholas Perez, MD, San Diego, CA
Chanelle Ramsubick, MD, Brooklyn, NY
Savitha Rao, MD, New Brunswick, NJ
Harris Raza, Orangeburg, SC
Brittany Reddish, Sacramento, CA
Ryan Richards, MD, Elizabethtown, PA
Amit Rotem, MD, Toronto, ON
Salman Salaria, MD, Bear, DE
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AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. We are deeply grateful to the following donors for their generous financial support of our mission.

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FOR YOUR INFORMATION

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aaccap.org.
The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

The new JobSource is simple and easier to use. Get to everything you need with just a few clicks. Visit us online at www.aacap.org and find JobSource under Quick Links or Member Resources.

With questions, please contact Samantha Phillips, Communications Manager, at sphillips@aacap.org.
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AACAP Pilot Research Awards
APPLICATION DEADLINE: APRIL 1, 2019
Provides $15,000 to members with a career interest in child and adolescent mental health research.

- AACAP Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows (Supported by AACAP)
- AACAP Research Award for Attention Disorders and/or Learning Disabilities
  - for child and adolescent psychiatry fellows and junior faculty (Supported by AACAP's Elaine Schlosser Lewis Fund)
- AACAP Pilot Research Award for General Psychiatry Residents (Funded by Industry Supporters)

AACAP Educational Outreach Programs (EOP)
APPLICATION DEADLINE: JULY 12, 2019
Provides the opportunity for residents to travel to AACAP’s Annual Meeting.

- AACAP EOP for Child and Adolescent Psychiatry Residents (Supported by AACAP’s Campaign for America’s Kids (CFAK), Endowment Fund, John E. Schowalter, MD Endowment Fund, and Life Members Fund)
- AACAP EOP for General Psychiatry Residents (Supported by AACAP’s Endowment Fund)

AACAP Systems of Care Special Program
APPLICATION DEADLINE: JULY 5, 2019
Provides support of $1000 to present a poster on a Systems of Care related topic during the “Systems of Care Special Program” at the AACAP’s Annual Meeting.

- Clinical Projects Scholarship
  (Co-Sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee)

Medical Students

All awards contingent upon available funding, and funders are subject to change.

AACAP Life Members Mentorship Grants – APPLICATION DEADLINE: JULY 12, 2019
Provides a grant of $1,000 to travel to AACAP’s Annual Meeting. (Supported by AACAP’s Endowment Fund)

- for medical students interested in networking with leaders in the field.

AACAP Medical Student Fellowships – APPLICATION DEADLINE: MARCH 4, 2019
Provides $3,500 to $4,000 stipend for 12 weeks of research training and covers travel to AACAP’s Annual Meeting.

- AACAP Jeanne Spurlock, MD, Research Fellowship in Substance Abuse and Addiction for Minority Medical Students (Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK))
  - for medical students focusing on substance abuse and addiction
- AACAP Summer Medical Student Fellowship Program (Supported by AACAP’s Endowment Fund)

AACAP Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award
APPLICATION DEADLINE: APRIL 15, 2019
Provides up to $8,000 in funding for a qualified child and adolescent psychiatry resident, fellow, or an early career psychiatrist (ECP) with demonstrated interest in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention. With the collaboration of a mentor, award recipients design a project to raise awareness in these subject area(s). (Supported by K. Lisa Yang, MBA, in honor of Marilyn B. Benoit, MD)

AACAP Psychodynamic Faculty Training and Mentorship Initiative
APPLICATION DEADLINE: MAY 1, 2019
Provides a stipend of $350 to cover travel expenses to AACAP’s Annual Meeting and an opportunity for residents to design a psychodynamic training project within their child and adolescent psychiatry division with the assistance of a mentor through the subsequent year. (Supported by the Samuel and Lucille B. Ritvo Charitable Fund)

AACAP Junior Investigator Award
APPLICATION DEADLINE: MARCH 18, 2019
Provides $30,000 a year for two years to a psychiatry junior faculty with a career interest in child and adolescent psychiatry. (Funded by AACAP and Industry Supporters)
Distinguished Member Awards
APPLICATION DEADLINE: MAY 1, 2019

AACAP Cancro Academic Leadership Award
Recognizes, in odd-numbered years, a currently serving or retired master teacher, which may include an associate or full professor, chair, dean, or equivalent level through teaching, mentorship, scholarship, and leadership to the field of child and adolescent psychiatry education.

AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities
Recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with intellectual and developmental disabilities.

AACAP Irving Philips, MD, Award for Prevention
Recognizes a child and adolescent psychiatrist and 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.

AACAP Jeanne Spurlock, MD, 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 children's mental health, and who contribute to the recruitment into child and adolescent psychiatry from all cultures.

AACAP Norbert and Charlotte Rieger Service Program Award for Excellence
Recognizes innovative programs led by AACAP members that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community.

AACAP Sidney Berman, MD, Award for the School-Based Study and Treatment 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.

AACAP Simon Wile, MD, Leadership in Consultation Award
Supported by the Child Psychiatry Service at Massachusetts General Hospital, acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry.

International Scholar Awards
APPLICATION DEADLINE: MAY 1, 2019

AACAP Paramjit Toor Joshi, MD, International Scholar Awards
Recognize mid-career international physicians who primarily work with children and adolescents providing mental health services outside the United States.

AACAP Ülkü Ülgür, MD, International Scholar Award
Recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

Academic Paper Award
APPLICATION DEADLINE: MAY 1, 2019

AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award
Recognizes the best published or unpublished paper written by an AACAP member using a psychodynamic psychotherapy framework.

For more information, visit www.aacap.org/awards.
Bay Area Clinical Associates (BACA) is a physician-owned and led organization offering evidence-based mental health services to youth and their families in the San Francisco Bay Area. BACA currently offers outpatient and intensive outpatient services in San Jose, Oakland and Menlo Park and is exploring other sites as well. We are looking for full-time psychiatrists to join our multidisciplinary team in each of our clinics.

Our mission is to set a new standard in providing evidence-based, multidisciplinary, integrated care. We provide all therapy and medication services at one convenient location. We do see adults, but generally only those ages 26 and younger or the parents of the children we treat. Psychiatrists are team leaders and will generally work with 2-3 LMFTs/LCSWs in delivering care. We are looking for committed individuals dedicated to the BACA mission and interested in doing more than just writing prescriptions all day. BACA is a fun, friendly place to work and we go on a first name basis for patients and staff. BACA offers the opportunity for clinicians to run groups and develop innovative treatment programs. As a psychiatrist at BACA, you will provide care to patients both in the outpatient and intensive outpatient programs (IOP). For the outpatient clinic, you would provide individual and family therapy, parent training and medication management. In the IOPs, psychiatrists serve as team leaders and perform evaluation and management visits along with psychotherapy; LCSWs/LMFTs offer individual and family therapy in the IOPs as well.

www.baca.org
state’s only pediatric hospital, are the clinical sites of the Division, which is nationally recognized as one of the top programs in the country in its breadth and depth of clinical, training, and research activities. Faculty have funded research projects totaling more than $12 million annually studying a wide range of psychiatric disorders in youth, as well as brain mechanisms of psychopathology, psychological reactions to illness, health disparities, and illness/risk prevention. The successful candidate will be expected to establish an independently-funded investigative clinical research program focusing on a topic relevant to one or more of the clinical programs in the Division. Priority will be given to areas such as Mood Disorders, Substance Use, Psychosis, Trauma, and suicide or other risk behavior. It is expected that at least 40% of the incumbent’s time will be devoted to research, and space will be provided. The position will include support for 40% of protected time for the faculty member’s research and scholarly activity/productivity. Multiple opportunities exist to teach child psychiatry fellows, triple board residents, medical students and psychology trainees. There are also many options to provide clinical care in outpatient and intensive care settings. The successful candidate must qualify for a full-time medical faculty position at the rank of Assistant or Associate Professor in the Department of Psychiatry and Human Behavior at The Warren Alpert Medical School of Brown University. Minimum requirements include: board eligibility or certification in child and adolescent psychiatry or psychology, excellence in patient care and teaching, and a commitment to scholarly participation in the clinical research programs of the Division of Child and Adolescent Psychiatry. Experience and evidence of productivity in research is essential. It is preferred that the candidate’s research experience focus on topics relevant to Division’s clinical programs. Brown University, Bradley Hospital and Hasbro Children’s Hospital are EEO/AA employers and encourage applications from minorities and women. Review of applications will begin immediately and will continue until the position is filled or the search is closed. Please apply online at http://apply.interfolio.com/58334.
For more information, please contact: Larry K. Brown, M.D., Division Director (Larry_Brown@brown.edu or phone 401-444-7573) or Jeffrey Hunt, M.D., Deputy Division Director (Jeffrey_Hunt@brown.edu).

Job Requirements:
The successful candidate must qualify for a full-time medical faculty position at the rank of Assistant or Associate Professor in the Department of Psychiatry and Human Behavior at The Warren Alpert Medical School of Brown University. Minimum requirements include: board eligibility or certification in child and adolescent psychiatry or psychology, excellence in patient care and teaching, and a commitment to scholarly participation in the clinical research programs of the Division of Child and Adolescent Psychiatry. Experience and evidence of productivity in research is essential. It is preferred that the candidate’s research experience focus on topics relevant to Division’s clinical programs.

Company: Bradley Hospital, Brown University (1138104)
Job ID: 11799763
http://jobsource.aacap.org/jobs/11799763

Get in the News!

All AACAP members are encouraged to submit articles for publication! Send your submission via email to AACAP’s Communications Department (communications@aacap.org). All articles are reviewed for acceptance. Submissions accepted for publication are edited. Articles run based on space availability and are not guaranteed to run in a particular issue.

- **Committees/Assembly.** Write on behalf of an AACAP committee or regional organization to share activity reports or updates (chair must approve before submission).

- **Opinions.** Write on a topic of particular interest to members, including a debate or “a day in the life” of a particular person.

- **Features.** Highlight member achievements. Discuss movies or literature. Submit photographs, poetry, cartoons, and other art forms.

- **Length of Articles**
  - Columns, Committees/Assembly, Opinions, Features – 600-1,200 words
  - Creative Arts – up to 2 pages/issue
  - Letters to Editor, in response to an article – up to 250 words

**Production Schedule**

AACAP News is published six times a year – in January, March, May, July, September, and November. The 10th of the month (two months before the date of issue) is the deadline for articles.

**Citations and References**

AACAP News generally follows the American Medical Associate (AMA) style for citations and references that is used in the Journal of the American Academy of Child and Adolescent Psychiatry (JACAP). Drafts with references in incorrect style will be returned to the author for revision. Articles in AACAP News should have no more than six references. Authors should make sure that every citation in the text of the article has an appropriate entry in the references. Also, all references should be cited in the text. Indicate references by consecutive superscript Arabic numerals in the order in which they appear in the text. List all authors’ names for each publication (up to three). Refer to Index Medicus for the appropriate abbreviations of journals.

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.
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**DISCOUNTS**
- AACAP members and nonprofit entities receive a 15% discount.
- Advertisers who run ads three issues in a row receive a 5% discount.
- Advertisers who run ads six issues in a row receive a 10% discount.

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