Inside...

President’s Column: Update on the Presidential Initiative ......................................................... 169
Owl Mentorship Program: Follow-Up of AACAP’s Life Members Fund Awardees ...................... 176
How Trauma Is Transmitted to Firefighters’ Families ................................................................. 178
AACAP Legislative Conference Wrap-Up ................................................................................. 192
October 22–27, 2018
Seattle, WA
Washington State Convention Center

 AACAP Member Registration Opens Online: August 1, 2018

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Early Bird Registration Deadline: September 13, 2018

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save the dates
COLUMNS
Neera Ghaziuddin, MD, Section Editor • neerag@med.umich.edu
President’s Column: Update on the Presidential Initiative • Karen Dineen Wagner, MD, PhD ........................................ 169
Resident Council Member Column: Advocacy: The Cases for Getting Involved • Lan Chi Krysti Vo, MD, and Abigail Cohen, MD .................................................. 170
International Relations Column: Global Mental Health: Child and Adolescent Psychiatry in the Mekong Delta of Vietnam (Việt Nam) • Kathleen Myers, MD, MPH, Tran Thien Thang, MD, and Dat Tan Nguyen, MD, MPH .......................... 171
AACAP Election Results .................................................. 173

COMMITTEES/ASSEMBLY
Ellen Heyneman, MD, Section Editor • eheyneman@uscd.edu
Women in Child and Adolescent Psychiatry Committee: Perseverance • Diane H. Schetky, MD. .................................................. 174
Life Members Committee: Owl Mentorship Program: Follow-Up of AACAP’s Life Members Fund Awardees • Cordelia Ross, MD, Gabrielle Carlson, MD, and Cynthia Pfeffer, MD .................................................. 176

FEATURES
Alvin Rosenfeld, MD, Section Editor • arosen45@aol.com
How Trauma is Transmitted to Firefighters’ Families • Kevin V. Kelly, MD .................................................. 178
Epigenetic Research and Early Identification of High-Risk Individuals • Michael Meaney, PhD .................................................. 180

MEETINGS
Jon (Jack) McClellan, MD, Section Editor • drjack@u.washington.edu
Register for AACAP’s 65th Annual Meeting Starting in August! .................................................. 183
Review the Extensive Programming Being Offered at the 65th Annual Meeting .................................................. 183
Promote Your Book at This Year’s Meeting .................................................. 183
Hotel Information for the 65th Annual Meeting .................................................. 185
Helen Beiser, MD, Art Show .................................................. 186

OPINIONS
Harmony Raylen Abejuela, MD, Section Editor • harmonyraylen@hotmail.com
Letter to the Editor: Clinical Benefits of Pharmacogenomic Testing • Joan L. Moreau, MD .................................................. 188
Depression Screening: Some Pros and Cons • Edmund C. Levin, MD .................................................. 190

LEGISLATIVE WRAP-UP
Government Affairs • govaffairs@aacap.org
AACAP’s 2018 Legislative Conference Wrap-Up • Michael Linskey .................................................. 192
From a Family Advocate’s Viewpoint • Paula Wilks-Wright .................................................. 193
AACAP’s 2018 Legislative Conference .................................................. 194

FOR YOUR INFORMATION
Communications & Member Services • communications@aacap.org
Membership Corner .................................................. 203
In Memoriam .................................................. 203
Welcome New AACAP Members .................................................. 204
AACAP Award Spotlight: Jeffrey Strawn, MD .................................................. 205
Thank You for Supporting AACAP! .................................................. 206
Facts for Families: Marijuana and Teens .................................................. 208
AACAP Policy Statement: Separating Immigrant Children From Their Families .................................................. 211
Classifieds .................................................. 212

Cover Photo: Our amazing AACAP family including members, families, and staff braved the chilly and windy winter weather to walk the halls of Congress spreading the word about children’s mental health. It was cold outside, but the sun was out, and the smiles on the faces of the entire team on the steps of the U.S. Capitol Building was worth it!
– Samantha Phillips, Communications Manager, AACAP

TABLE of CONTENTS
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

FUNCTION AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

■ Establishes and supports the highest ethical and professional standards of clinical practice.

■ Advocates for the mental health and public health needs of children, adolescents, and families.

■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.

■ Liases with other physicians and health care providers and collaborates with others who share common goals.

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Update on the Presidential Initiative

Karen Dineen Wagner, MD, PhD

I am delighted to provide an update about the Presidential Initiative on Depression Awareness and Screening in Children and Adolescents. The Presidential Task Force represents many AACAP committees and includes members Tami D. Benton, MD, Graham J. Emslie, MD, Sandra L. Fritsch, MD, J. Michael Houston, MD, Sansea Jacobson, MD, Joan Luby, MD, Karen Pierce, MD, Neal Ryan, MD, Heather J. Walter, MD, K'ai- ping Wang, MD, and Timothy Wilens, MD. Carmen Head, MPH, serves as AACAP’s staff liaison. We have had monthly telephone calls since the Annual Meeting, which have been very productive. Here are some of the activities.

- Consistent with the theme of screening for depression, a policy statement will be developed regarding universal screening for depression in youth.
- A Clinical Practice Guideline on Assessment and Treatment of Depression in Children and Adolescents is under development. The Agency for Healthcare Research and Quality is currently completing a systematic review on the treatment of childhood depression, which will be the foundation for this clinical practice guideline. (The Clinical Practice Guideline will replace the 2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders).
- The Parent’s Medication Guide on the Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families (last updated 2010) is currently under revision.
- All of the existing materials on AACAP’s Depression Resource Center are being reviewed, revised, and updated as needed. There is an updated Facts for Families on Depression in Children and Teens.
- There will be an edition of the Child and Adolescent Psychiatric Clinics of North America on Depression in Special Populations. Sixteen committees have agreed to write chapters in this edition. I will discuss this edition in more detail as the topics are finalized. The planned date of publication is July 2019.
- An article written by Dr. Wang in the previous edition of AACAP News provides important information about codes for reimbursement for depression screening, as well as other screening instruments.
- The Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP) and JAACAP Connect will publish a special series on depression in youth. I encourage you to submit manuscripts on the topic of depression, as well as programs that have been implemented for depression screening in youth and processes by which youth who screen positive receive treatment.
- The 2018 Research Institute at AACAP’s Annual Meeting will focus on mood disorders, specifically depression and suicidality.
- David Brent, MD, an internationally recognized expert on depression and suicidality, will be the Karl Menninger, MD, Plenary speaker at this year’s Annual Meeting.
- Dr. Luby, an internationally recognized expert on mood disorders in youth, particularly preschool depression, will be interviewed for the Presidential Interview at this year’s Annual Meeting.
- I have given presentations at the American Psychiatric Association, universities, and Regional Organizations about the Presidential Initiative. Please contact me if you would like me to present at your regional organization.

I look forward to giving you periodic updates on the Presidential Initiative, and I am very grateful for the support of the membership and AACAP staff in this initiative.

Dr. Wagner is Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Texas Medical Branch, Galveston, and is president of the American Academy of Child and Adolescent Psychiatry, 2018 to 2020. Disclosure: Dr. Wagner has served as councilor and AACAP delegate to the Texas Society of Child and Adolescent Psychiatry, on the Scientific Advisory Board of the Anxiety Disorders Association of America, and on the Scientific Council of the Brain and Behavior Research Foundation (no financial compensation was received). She has received honoraria from AACAP, the American Psychiatric Association, the American Society of Clinical Psychopharmacology, the Nevada Psychiatric Association, UBM Medica US, and CME Outfitters. She may be reached at kwagner@aacap.org.
Advocacy: The Case for Getting Involved

Lan Chi Krysti Vo, MD, and Abigail Cohen, MD

At a time of controversial political climate, children’s health should unite people with bipartisan support. Advocacy is defined as speaking out in the service of our patients—something child and adolescent psychiatrists do on a daily basis when we contact schools, service organizations, and insurance companies to help our patients get the care they need. A natural extension of this work is moving to advocate for our patients at the community, state, and national level to bring about a systemic change.

As child and adolescent psychiatrists, we see the direct clinical impact of policy changes on children’s mental health and are in unique positions to advocate on behalf of our patients, who are some of the most vulnerable members of our society. The legislators may not be aware of the downstream effects of health policies. Mental health funding and resource allocation directly affects our profession and our patients as individuals. By speaking up, we not only help our patients, we help our representatives serve their communities.

We were fortunate to attend previous AACAP’s annual Legislative Conferences that ingrained in us, as trainees, the importance of advocacy. The conference is an opportunity for members and children’s mental health advocates from across the country to meet with legislators on Capitol Hill with the goal of shaping public health policies. AACAP’s orientation offered a crash course in advocacy, including how to talk to legislators and briefings of current bills affecting children’s mental health.

AACAP makes it easy so that even first-time attendees can meet with their representatives and effectively advocate with a united voice.

At a time when the future seems so uncertain, we were nervous that our messages would fall on deaf ears. On the contrary, we found that meeting with politicians and their staff was exhilarating, and they carefully listened to our insight and personal experiences. It was encouraging to meet representatives who were eager to ensure that children’s quality mental health is a priority in health care policies. Though some representatives’ offices were less receptive to our message, we continue to engage with them and know that they are tracking encounters with their constituents. The louder our united voices are, the more they will listen.

There are simple steps one can take to start advocating for children’s mental health on a broader scale. AACAP’s local chapters allow you to work with colleagues in your area to address issues impacting your local community and offer opportunities to forge alliances with community members and politicians to effect change. Advocacy can be as simple as contacting your local representatives, through letters, phone calls, or town hall meetings, to let them know the issues you care about. Local advocacy can be highly effective as there are many opportunities to engage your representative on a personal one-on-one basis. One of the simplest steps members can take is to donate to the American Association of Child and Adolescent Psychiatry Political Action Committee (AACAP-PAC), a separate organization from the Academy that provides resources for political advocacy. As a member of AACAP-PAC, you can subscribe to email updates on current legislations and “Action Alerts,” where clicking a link will send pre-written messages to your representatives.

The Legislative Conference inspired us to continue our advocacy work, and reminded us that even when times feel hopeless, there are concrete steps we can take to help our patients get the resources and funding they need. As child and adolescent psychiatrists, advocacy expands our reach beyond our individual patients to ensure that youth across America have access to quality care.

Dr. Vo is a second-year child and adolescent psychiatry fellow at the Icahn School of Medicine at Mount Sinai and AACAP’s John E. Schowalter, MD, Resident Council Member. She may be reached at doctorkvo@gmail.com.

Dr. Cohen is a first-year child and adolescent psychiatry fellow at the Icahn School of Medicine at Mount Sinai. She may be reached at abicohen@gmail.com.
Global Mental Health: Child and Adolescent Psychiatry in the Mekong Delta of Vietnam (Việt Nam)

Kathleen Myers, MD, MPH; Tran Thien Thang, MD; and Dat Tan Nguyen, MD, MPH

“If we have no peace, it is because we have forgotten that we belong to each other.”
~Mother Teresa

Child and adolescent psychiatrists have long been peace-makers for youth—in their families, schools, and communities. Do we have a peacemaking role on a global scale? As low and middle income countries (LMICs) recognize the developmental and mental health needs of their increasingly young and stressed populations, they face a problem that is well known to countries with high income economies—a shortage of specialists to help their youth. Optimizing youth-development, education, and mental health paves the path to peace. The United Nations (UN) Sustainable Developmental Goals and the UN Convention on Rights of the Child (CRC) envision an inclusive society in which health and education contribute to the welfare of all.¹ The CRC further stipulates that children with disabilities cannot be excluded from free and compulsory education based on their disability.² To achieve these goals, children with developmental disabilities, mental health conditions, behavioral disorders, and neurological disabilities need greater access to health care, early childhood care, education, developmental services, and mental health care—all areas integral to what child and adolescent psychiatrists do in their practices. We are well poised for global collaboration with physicians in LMICs.

Kathleen Myers, MD, joined the Medical Education Exchange Team (MEET) from Seattle, Washington, to collaborate with physicians at Can Tho University of Medicine and Pharmacy (CTUMP) and Can Tho Children’s Hospital in Vietnam. Can Tho has a population of 1.2 million, the fifth largest city in Vietnam, located 105 miles southwest of Ho Chi Minh City (aka Saigon). It serves the entire population of the Mekong Delta and has been termed the “Rice Basket of Vietnam,” given its fertile soil and unique food products that are found in its floating fish farms and floating markets. In 2014, Richard Veith, MD, from the University of Washington (UW) joined MEET to establish an academic collaboration with the CTUMP.

The collaborative Child and Adolescent Mental Health Team at Can Tho University of Medicine and Pharmacy (CTUMP). On left: Nguyen Thai Thong, MD, and Elizabeth McCauley, PhD; In middle: Lynn Vigo, MSW, Richard Veith, MD, Kathleen Myers, MD, MPH, and Tran Thien Thang, MD; On right: Pamela Collins, MD, MPH, Gary Stobbe, MD, and Dat Tan Nguyen, MD, MPH.

continued on page 172
Department of Psychiatry through their Chair, Nguyen Van Thong, MD. In 2017, he invited Dr. Myers to join UW and MEET. In collaboration with Dat Tan Nguyen MD, MPH, at CTUMP School of Public Health, Dr. Myers presented didactics on developmental psychopathology and clinical disorders. Dr. Thong, along with newly appointed psychiatry faculty Nguyen Thai Thong, MD, arranged clinical interviews of children through Can Tho Psychiatric Hospital. Nguyen Ngoc Viet Ngã, MD, facilitated clinical evaluations of children. We discussed collaborative models of care for mental health services at the Children’s Hospital. These discussions revealed the pediatricians’ interest in autism spectrum disorder. Similar to many LMICs, Can Tho has an increasing awareness about the prevalence, clinical challenges, and differential diagnosis of autism spectrum disorder. Clearly, improved formulations will result in appropriate interventions and the development of services. We are hopeful that access to such expertise in Can Tho will reduce the burden on families of having to travel to HCMH for evaluation, establish pediatricians’ role in early identification, help schools provide educational experiences, and aid communities in developing early intervention specialists.

The timeliness of addressing this need should be mentioned. For instance, during the past decade, the government of Vietnam has recognized the need to develop psychosocial services. They have promoted the development of the discipline of social work which has increased awareness of the need for other psychosocial services. Recently, Can Tho built the 500 bed Children’s Hospital and identified a pediatrician to lead a collaboration with UW/MEET to develop autism spectrum disorder services.

In April 2018, the Child and Adolescent Can Tho Mental Health Team for UW/MEET was born and travelled to Can Tho: Gary Stobbe, MD (neurology), Elizabeth McCauley, PhD (psychology), Lynn Vigo, MSW (mental health family therapist), Pamela Collins, MD, MPH (Director, Global Mental Health at UW), Dr. Veith, and Dr. Myers. To our surprise, we met a recently graduated doctor, Tran Thien Thang, MD, who is specializing in child and adolescent psychiatry at CTUMP and the Children’s Hospital with a focus on autism spectrum disorders. In collaboration with Dr. Thang and Dr. Dat, we presented to medical and educational professionals a workshop on autism spectrum disorder from global epidemiology to evidence-based interventions. With Dr. Thang’s guidance, we interviewed nine children, two-to-13 years old, to hone diagnosis and interventions. Parents were open, trusting, and very aware of their children’s needs. They especially appreciated viewing Ms. Vigo’s video describing her experience in raising a child with autism spectrum disorder and learning that their challenges transcend national boundaries. They shared their difficulties in enrolling their children in schools and getting other services. Despite a law for compulsory education, schools may refuse to enroll children with special needs, if determined that the school cannot adequately meet the needs of the child. One mother, a teacher, shared her creativity in bringing her son to her classroom so that he can informally obtain education as well as the much-needed socialization. Other families did not have many options. They noted that distance limited being able to obtain services in HCMC, often resulting in worry for the child’s future. Clearly, these are no different from the concerns of families from countries with high economies. It was heartening to observe that the families did not allow cultural stigma to prevent them from searching for answers to help their children, and many were so thankful to have Dr. Thang practicing in Can Tho—his hometown.

Our experience underscores larger trends in global mental health in recognizing the burden of illness to the child with autism spectrum disorder, his/her family, the community, and the importance of building skills among pediatricians. Creating community resources, as LMICs struggle to meet young people’s physical and mental health needs with limited resources, is also a key factor.

In light of our experience, we encourage child and adolescent psychiatrists to consider bringing their expertise and discretionary time to our global colleagues. Those in the latter stages of their careers will undoubtedly feel rejuvenated by their new colleagues and grateful families as they provide opportunity to change the misperception from “families’ fault” to understanding a neurodevelopmental disorder with a need for health, educational, community support as well as an opportunity for research.

One potential risk of such global mental health collaboration is “medical imperialism,” i.e., the imposition of western concepts of illness on the rest of the world and upending cultural beliefs about the meaning of illness. Therefore, indigenous narratives must be considered and integrated with western knowledge to respect cultural identities and preserve community benefits. We need colleagues, like Dr. Thang and Dr. Dat, to adapt scientific knowledge into their practices and teaching. We may then strive to reach the UN’s and CRC’s goals to provide equitable mental health care and education to all children of our shared globe.

Our collaboration with Dr. Thang, Dr. Dat, Dr. Thong, Dr. Ngã, CTUMP, and Can Tho Children’s Hospital will continue when UW/MEET returns in October 2018. We are confident that together we will develop a culturally sensitive model of care for children with autism spectrum disorder in Can Tho. Such collaboration seeks to promote peace within our global family through a shared vision for the welfare of our youth. We sincerely hope that sharing our experience will promote discussion with other AACAP members who are involved in global mental health for youth.

References

Dr. Myers is Professor of Psychiatry and Behavioral Sciences at the University of Washington and Director of Telepsychiatry at Seattle Children’s Hospital in Seattle Washington. Dr. Myers is co-chair of AACAP’s Telepsychiatry Committee. She may be reached at kathleen.myers@seattlechildrens.org.

Dr. Thang is a lecturer in the Department of Psychiatry at Can Tho University of Medicine and Pharmacy (CTUMP) and medical staff in the Psychology and Behavioral Clinic at the Can Tho Children’s Hospital. He obtained his medical degree from CTUMP and is now completing his master’s degree at the University of Medicine and Pharmacy in Ho Chi Minh City. He may be reached at ttthang@ctump.edu.vn.

Dr. Nguyen is a lecturer, Vice Head of Biostatistics and Demography, Assistant for Scientific Research and International Cooperation at the Faculty of Public Health, and Vice Head of Training, at CTUMP. He obtained his medical degree from CTUMP and a Master’s Degree of Public Health from Queensland University of Technology, Brisbane City, Australia. Currently, he is a doctoral (PhD) candidate at the Vrije Universiteit (VU), Amsterdam, Netherlands. He may be reached at ntdat@ctump.edu.vn.

Seattle was ranked #8 best city in the country for clean-tech economy and is home to 11 Fortune 500 companies.

AACAP Election Results

AACAP’s 2018 election concluded on May 31 at 11:59:59 pm EDT.
On behalf of AACAP, thank you to everyone who voted in this important election.

Please join me in congratulating the following members whose terms begin in October 2018 at the end of the Annual Meeting in Seattle, WA:

Councilor-at-Large (October 2018-2021)
Mary S. Ahn, MD
Boris Birmaher, MD

Nominating Committee (October 2018-2020)
William Arroyo, MD
Sandra L. Fritsch, MD, MSEd

These elected members are a prestigious group of professionals that have consistently demonstrated their support and dedication to the mission of AACAP and its members. We wish them all the best in their new positions.

I would also like to thank AACAP’s Nominating Committee, led by Gregory K. Fritz, MD, for all their work determining this year’s election slate. Members of the committee include Cheryl S. Al-Mateen, MD, John E. Dunne, MD, Sharon L. Hirsch, MD, and James J. Hudziak, MD.

Sincerely,

Karen Dineen Wagner, MD, PhD
President

AACAP Election Policy

(approved by the Executive Committee March 23, 2001)

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.
I was drawn to medicine from the age of four when I came down with typhoid fever and was given a toy doctor’s bag at Christmas. When I subsequently had measles pneumonia at age nine, I decided that I’d rather be a doctor than a patient. I had little support for entering the profession of medicine but persevered nonetheless. In college, I studied art and crammed in the prerequisite pre-med courses. I wondered if I had sufficient talent to pursue art and if I had the stamina for medical school. I applied to many of the East Coast medical schools and got no responses from them. The prevailing views then were that women would marry, have children, and drop out of medical school or that they lacked the stamina for medicine. I was fortunate to be accepted on the spot by the Dean of Case Western Reserve University School of Medicine. On my way to Cleveland to join the class of ’65, I came down with Hepatitis A and had to defer medical school for a year. After a few months of convalescence, I was hired by my biology professor at Sarah Lawrence College to assist in her grant for research on hormonal effects on melanoma on mice and learned histology and patience. In 1962, I was able to join the class of ’66 which became known as the class with all the women: 13 out of 85 students!

The men in our class were supportive and not receiving grades made us all less competitive. I met my future husband, an upper classman, in the elevator in my second week of classes. Our courtship took place mostly in the library, as our lives were consumed with medicine. We married the following summer. I graduated in 1966, then did my internship at Babies and Children’s Hospital in Cleveland. I was on call every other night and my husband every third, so we did not see much of each other. The pace was exhausting, and I worried about making an error due to sleep deprivation. I was drawn to psychiatry and child psychiatry where, as a resident, I’d only be on call every fourth night.

Maternity leave was unheard of in those days, so I planned my pregnancies to coincide with vacation time. James arrived early, and I was amused that the obstetric staff labelled me an “elderly primipara” when I was only 29. I returned to work two weeks later to begin my child psychiatry residency. I became the first person at University Hospital to do a part-time residency, and I worked five hours a day. Staff and residents still expected me to work full time, but I learned to say no. My son, Scott, arrived towards the end of my residency, on the day before I was to testify in court. We were fortunate to have an excellent nanny during our Cleveland years who my sons viewed as one of our family. I learned that raising children could be humbling and learned empathy for mothers. I recall suggesting strategies for toilet training to the mother of a young patient. These strategies worked for her, but I got nowhere with them at home.

In 1974, upon completing our training, we moved to Oregon where Charlie got a job with the Veterans Administration. I had a part-time job directing the Child Psychiatry Clinic at University of Oregon Health Science Center which gave me ample time with my sons when they were not in school or daycare at the university. When my marriage failed, the boys and I returned to Connecticut where I had family. I married on the rebound and went from being Diane Browning to Diane Schetky. I started a private practice in a small addition to our home which allowed me to keep tabs on the boys. One day, I overheard Scott getting off the school bus saying to our dog, “Now Moose you must not eat the patients!” I wondered if he might be jealous of them. I learned a lot about the stresses of divorce and blended families. My children were now bi-coastal, but they’d visit with the father in California during their vacation time. Our relationship with him remained amiable. I kept hoping my new husband would warm up to my sons but that never came to fruition.

I divorced and kept the name Schetky only because I had published under it. In 1986, my sons and I moved from affluent Wilton, Connecticut, to the village of Rockport, Maine, where I knew almost no one. I discovered that there were only two other child psychiatrists in private practice in the entire state. My office was over the garage of my house, and I
could set my own schedule and keep an eye on my youngest son when he came home from high school. I was told by a local psychiatrist that I could never make a living in Rockport, but I knew I would succeed because of my training in child and adult psychiatry and being comfortable going to court. In addition, some mothers were looking for role models for their daughters. I made some house calls to see how Maine people lived, which was an eye opener. I got referrals from the Department of Health and Human Services, and my practice encompassed people of all ages and backgrounds. I would often get called to court to testify on sexual abuse and child custody cases.

I was on call all the time, but my patients respected my privacy and rarely called me at home. If I left Maine to go to professional meetings, I’d get coverage from a pediatrician or adult psychiatrist. I compensated for the paucity of colleagues by keeping in touch by phone with other psychiatrists, including Elissa Benedek, MD, with whom I was editing/writing books on child and adolescent forensic psychiatry. I enjoyed doing psychotherapy but increasingly became frustrated by the restraints insurance companies put on my practice. I closed my psychotherapy practice in 2000 but continued doing forensic evaluations and part-time work for the State Forensic Service until I retired in 2007. While I had not done a residency in forensic psychiatry, I attended meetings of the American Academy of Psychiatry and Law, studied hard, and obtained board certification in Forensic Psychiatry.

Living in a small town, one is likely to see one’s patients all about town. I had to be on my best behavior in public and learned how to deal with patients I saw in the supermarket or the town dump or were being introduced to me by someone at a party. I became vigilant about boundaries and this led to 20 years of my Ethics columns in AACAP News. I remembered the mantra I learned while doing part-time work at the Maine State Prison: “Nothing in and nothing out” worked well in my practice, as well.

As I look back, I wonder how I managed to balance career and family as a single mother and find time to write/edit six books and publish over 50 articles/chapters, mostly on forensic child psychiatry without the help of a secretary or the internet. My career has taken me to places I never expected to go, including Maine State Prison. I volunteered to facilitate bereavement groups there for eight years and helped start a hospice volunteer training program for inmates. Adversity has taught me compassion, and I have found joy in helping others and continue to do so as a hospice volunteer. I have my sons to thank for their support over the years and through troubled times.

Dr. Schetky retired from private practice in 2007 and now lives in a retirement community in Topsham ME. She volunteers with Hospice, is a docent at the Bowdoin College’s Peary Macmillan Arctic Museum, and enjoys writing poetry far more than forensic reports. She has published her three books of poetry, most recently, Taking Flight. She may be reached at arcticpoppy1@gmail.com.
Owl Mentorship Program: Follow-Up of AACAP’s Life Members Fund Awardees

Cordelia Ross, MD, Gabrielle Carlson, MD, Cynthia Pfeffer, MD

"If I have seen further it is by standing on the shoulders of giants.”
~Isaac Newton

Mentorship has been described as a two-way gift exchange, simultaneously humbling the wise and experienced, while inspiring leaders of the future. As such, mentorship has been a fundamental aspect of AACAP, particularly among the Life Members. In fact, it has been one of the Owls’ cornerstone missions, in order to enhance the field of child and adolescent psychiatry (CAP). At AACAP’s Life Members Committee meeting at the annual AACAP meeting in October 2017, Gabrielle Carlson, MD, proposed doing a follow-up of medical students, residents, and child and adolescent psychiatry fellows funded by Owls to find out how many had entered or stayed in the field and were members of AACAP. This report highlights salient findings of that brief study.

In the span of five years (2011-2016), the Owls provided funding of over $150,000 to support 158 trainees in attending AACAP’s Annual Meeting. In this period of time, the Owls granted 76 AACAP Life Members Mentorship Grants for Medical Students; of these, 59 (77.6%) are current AACAP members. Similarly, the Owls granted 82 Educational Outreach Program awards for general psychiatry residents and CAP residents; of these, 76 (92.7%) are active members.

To obtain more detailed data on the results of our mentorship programs, we decided to focus on surveying the 76 medical students who received awards from 2011-2016 given their undifferentiated career status at the time. We used Survey Monkey to obtain our data. Due to limited contact information, we were able to contact a total of 66 (66.0%) former medical students who received an AACAP Life Members award between the years 2011-2016. Fifty-one (77.0%) individuals responded, and their current status includes 40 (78%) trainees and 11 (22%) early career psychiatrists. The trainees’ current status includes 20 (50%) residents, 10 (25%) CAP fellows, and 7 (18%) medical students.

Notable findings about medical students who received awards from 2011-2016 include the following:

- 96% of survey respondents are current AACAP members.
- 15% of respondents are board-certified in CAP; 29% are board-certified in general psychiatry, and 69% are not yet certified because they are still in training.
- 88% of respondents found the award to be helpful for networking.
- 79% found the award helpful for gaining mentorship.
- Award recipients also found the award to be helpful for learning about training opportunities (40%), career/job opportunities (17%), and research opportunities (12%). It was helpful for increasing one’s interest in CAP/AACAP and getting involved with an AACAP committee.
- Respondents noted that they greatly enjoyed meeting Owls, particularly at the annual Life Members dinner. They enjoyed receiving advice from seasoned child psychiatrists, those at the other end of the career trajectory, and found it inspiring to hear about their career progression. Several described the dinner as “the best part of this award.” One award recipient eloquently wrote, “My favorite event! The location was beautiful and the impact of the Life Members was deeply conveyed. I had wonderful conversations and even went on a walk in the rain uptown with esteemed members of the field. It was an evening I will always remember.”

This survey had several limitations. First, our findings are limited and likely inflated by self-report bias, as those for whom we had contact information and those who responded to our survey may be more likely to be actively engaged in AACAP. Second, we did not survey those who were residents or CAP fellows at the time of award, but expect that even more are current AACAP members, as suggested by data from the 158 total award recipients above.

Nevertheless, these results are particularly important given that medical students and residents are in their formative years deciding career trajectories – to choose psychiatry or not, and to pursue further training in CAP or not. This is critical given the
well-documented severe mismatch between demand for CAP providers and the actual number of practicing clinicians, with AACAP projecting a shortage of more than 4,000 CAP physicians by 2020. Early exposure to the field of CAP through attendance at AACAP’s Annual Meeting provides medical students with unique educational, research, and clinical opportunities and valuable social and professional connections. This not only encourages them to pursue a career in CAP but also ultimately helps to combat the dire workforce shortage that our field faces, particularly in underserved areas.

In addition to merit- and experience-based qualifications, preference is given to award applicants who live in those underserved areas with limited CAP services.

I (Cordelia) am fortunate to have received three awards from the Life Members and AACAP’s Endowment Fund. I attended my first Annual Meeting as a third-year medical student, where I was struck by the sheer volume of speakers, workshops, and social events squeezed into a five-day conference. The experience was formative. It was at my first Annual Meeting that I realized I had found my people – passionate trainees and child psychiatrists who shared my enthusiasm for promoting children’s mental health.

Mentorship has played a pivotal role in my training thus far and will undeniably remain an important aspect of my life. I am proud to be a five-year member of an organization that emphasizes mentorship and encourages trainees of all levels to become involved in programming and decision-making. While continuing to seek mentorship for myself, I have also worked to create similar opportunities for others. Through my involvement with the MSR Committee, I hope to help expose trainees to the many perks of CAP, encourage more students to pursue CAP, and foster connections among those with similar interests, as my peers and mentors have done for me.

We thank Anneke Archer, AACAP’s Program Manager of Training & Education, for her assistance in tabulating the data and for her work with trainees. We also thank those members of AACAP’s MSR Committee who volunteered to assist in the selection of Life Members award recipients. This is exactly the kind of involvement and participation that mentorship in AACAP fosters.

Lastly, we hope that our survey findings highlighted the important and lasting effects that the Life Members awards and opportunity to attend AACAP’s Annual Meetings had on trainees, particularly those at early and undifferentiated stages of their careers. We also hope that our findings will encourage our readers to consider contributing to the cause and supporting future generations of child and adolescent psychiatrists.

Dr. Ross is currently a PGY-3 at the MGH/ucan Adult Psychiatry Training program affiliated with Harvard Medical School; she is in the program’s five-year child and adolescent psychiatry track. She has been an AACAP member since 2013 and has served on the Committee on Medical Students and Residents for the past three years. She may be reached at cordelia.ross@mgh.harvard.edu.

Dr. Carlson is professor of Psychiatry and Pediatrics at Stony Brook University School of Medicine and AACAP’s President-Elect. She may be reached at Gabrielle.Carlson@stonybrook.edu.

Dr. Pfeffer is a Professor of Psychiatry at Weill Cornell Medicine and co-chair of AACAP’s Life Members Committee. Dr. Pfeffer has continued aspects of her research on childhood bereavement and suicidal behavior and has a psychiatric practice for children, adolescents, and adults. She may be reached at cpfeffer@med.cornell.edu.

Many Seattle residents use a bicycle for their daily commute. Seattle police force was outfitted with bicycles in 1987.
How Trauma Is Transmitted to Firefighters’ Families

In the 9/11 tragedies, over 300 New York Fire Department (NYFD) members lost their lives. Kevin V. Kelly, MD, rose to a great psychiatric challenge; the NYFD is a family unto its own and lets no professional become an insider. Yet, Dr. Kelly worked relentlessly to be accepted and to help the survivors and their families with the emotional sequelae of 9/11. They finally let him in a bit as a witness to their grief and an intervenor. What he learned about families and children enriches us all; what he gave to our country and my city deserves our enormous gratitude. –Alvin Rosenfeld, MD, Features Editor

Kevin V. Kelly, MD

In the aftermath of the 9/11 attacks, I began serving as a psychiatric consultant to the New York City Fire Department (FDNY). Since then, I have had direct clinical contact with about 1,800 individuals in this capacity. Most were uniformed members of the FDNY, but I have also seen their spouses and other family members. Firefighters have told me about interactions with their families, experiences that have given me the opportunity to consider how the intergenerational transmission of trauma might take place in this population.

The firefighter’s relationship to his family (only about 0.3% of New York City firefighters are women) involves some ambivalence. On the one hand, firefighters tend to be very involved in their children’s lives. Their schedule permits more daytime hours at home than most working fathers have, and they are often involved in coaching youth sports. Their tendency to preserve their enjoyment of latency-age pleasures is captured in one firefighter’s description of the firehouse as “The Land of the Lost Boys.” On the other hand, a firefighter belongs, for psychological purposes, to two families, and there is often tension between the firefighter’s allegiances to the family at home and to the brethren at the firehouse. A firmly-rooted ethos, intended to protect the firefighters’ families, forbids discussing the dangers and horrors they encounter daily with anyone outside the brotherhood (including mental health professionals like me); often this rule is made explicit in the form of a sign on the firehouse wall admonishing “Keep It in the House.” Of course, their significant others are aware of what they do, and the father’s silence can aggravate the sense of fear and isolation the mother and children feel.

Those dangers and horrors have always rendered firefighters vulnerable to post-traumatic stress disorder (PTSD), but the attack on the World Trade Center (WTC) multiplied the scale of both psychological trauma and the resultant symptoms for members of the FDNY. Three hundred forty-three FDNY members died in the collapse; for the next nine months, all active members participated in the horrifying rescue and recovery work; and increasing numbers of those participants continue to be diagnosed with debilitating and life-threatening physical illnesses related to their WTC exposure.

In my observation, firefighters with 9/11-related PTSD show all the typical symptoms associated with this disorder, but their irritability and social withdrawal are most prominent, and are particularly likely to affect their families. The symptom most often responsible for overcoming their reluctance to seek treatment is usually described as “taking it out on the kids” or “biting everyone’s heads off.” When the recovery effort came to an end, firefighters who were physically reunited with their families became psychologically withdrawn from them. The ethos of protectiveness combined with the symptomatic tendency toward withdrawal led the firefighters to avoid contact with their families even when they stayed at home. The families often experienced this absence as if the husband/father had died along with his brethren on 9/11, and the firefighter’s unconscious identification with the dead may well lie behind his withdrawal.

In other situations, the firefighter’s reaction took the form of hypervigilant and counterproductive worry about his family’s welfare. A firefighter involved in disaster preparedness became convinced that another attack on New York was inevitable and decided to move his family to a rural area in the Northwest. His children opposed leaving their schools and friends, and he became so paralyzed by the conflict between his fears for their safety and their wishes that he sold their house but failed to buy a new one. The family had to move in with relatives for several months. A dispatcher, whose radio contacts with the firefighters in the WTC were the last conversations many of them had, became so preoccupied with a fear of intruders that he had an extensive system of bright lights and security cameras installed in the backyard where his children played. At first, the children enjoyed the novelty, but they soon internalized his fears and stopped playing outside. The children’s behavior in this situation could be interpreted as an unconscious identification with the traumatized parent, but a more direct and compelling understanding would focus on the effect of the parent’s bizarre behavior on the child.

In these families, the man who was once busily and happily involved in his children’s activities may have disappeared from the home for many months, and when he returns he is likely to withdraw in solitude. If he does emerge, he may be over-solicitous and worried about the child, and then fly into a fit of rage minutes later. When he leaves for work, the child’s gnawing but unspoken fear that he may not return alive is even more pressing. The child’s experience
of the father changes to an insecure and unpredictable one.

The results of this admittedly small, idiosyncratic sample suggest that “inter-generational transmission of trauma” may be misleading. The term seems to imply that, in some unconscious fashion, perhaps involving a version of projective identification, a trauma in the parent’s life is recreated in the child’s psyche. The examples offered here suggest a more mundane theory, that the traumatized parent becomes unable to perform basic parenting functions. Because of fear, conflict between work and family, psychological withdrawal, hypervigilance, and intermittently unmanageable rage, the traumatized father cannot provide a stable, trustworthy, available, and reassuring presence for the child. The result is not exactly a repetition of the father’s specific trauma in the child’s mental life, but it can be equally devastating.

Fortunately, there are also situations in which the children are able to rescue the rescuers. As noted above, the firefighter’s recognition of the effect his symptoms have on his children is often his motivation to seek treatment, and a benevolently manipulative appeal to parental responsibility can help in overcoming the firefighter’s resistance to using psychotropic medication. In those who consider suicide, it is usually the anticipated effect on the children that keeps them from carrying it out. A number of 9/11 survivors found fulfillment, and some relief of guilt, in serving as surrogate fathers to the children of their deceased brethren. Finally, many retirees have found satisfaction in the role of “Mr. Mom.” Involuntary retirement, even when accompanied by disability compensation, requires a major psychological adjustment, but when family circumstances permit retirees to become full-time parents, the transition can become tolerable and even welcome.

Finally, when the men eventually achieve some mastery of the trauma, the resulting change in their attitudes often leads to a different and more constructive approach to parenting. Firefighter Mike was buried in the rubble of the collapse, and he spent some months at home recovering from his injuries. He recalled that, when he was leaving home for his first day back at work, his five-year-old daughter was obviously worried and asked him whether she could do anything to help. His first impulse was to adopt the protective stance, as he would have in the past, reassuring her that she needn’t worry and the firemen will take care of everything.

“But,” he explained, “something told me that wasn’t the right response. So instead I said, ‘You know, there is something you could do; you could give me a hug, and then I could take your hug down to the firehouse and pass it around to all the other guys, and that way everyone would feel better.’” This affirmation of the girl’s efficacy in helping her father and his brothers seems likely to serve her better than the protective denial that prevailed before 9/11.

Anyone interested in reading an extensive discussion of these issues and experiences can find it in my chapter in Fromm, G, ed., Lost in Transmission (Karnac Books, 2011).

The clinical examples described here are composites of real individuals’ stories.

Dr. Kelly is Clinical Professor of Psychiatry and of Ethics in Medicine at Weill Cornell, and a Medical Officer in the FDNY. He may be reached at kevinkellymd@gmail.com.

The famous Space Needle was built for the World’s Fair in 1962.
Epigenetic Research and Early Identification of High-Risk Individuals

Most mental disorders show a peak age of onset during adolescence. Although identifying high-risk individuals early could lead to cost-effective prevention, we are currently poorly positioned to meet this challenge. While specific environmental conditions are statistically significant predictors of risk for the population as a whole (e.g., parental mental health, socio-economic disadvantage, birth outcomes, etc.), neither environmental nor genetic factors alone adequately predict a particular child’s risk for psychopathology. Most account for only 5-10% of the relevant variation. Studies show that even children exposed to extreme forms of childhood adversity show considerable inter-individual variation in mental health outcomes. Likewise, in the absence of pathogenic environmental conditions, genetic predispositions commonly lie dormant. The challenge is to capture the relevant gene-environment interactions that shape mental health.

Effectively identifying high-risk individuals will require integrating advances in biological sciences into our understanding of development and psychopathology. The challenge is to define the actual impact adversity has at the individual level and to develop effective childhood biomarkers. Epigenetic research may provide a fruitful approach.

Epigenetic marks are biochemical modifications to the genome, the most stable of which target the DNA and its accompanying histone proteins. Epigenetic signals vary from one tissue to another and regulate gene expression, producing tissue- and cell type-specific patterns of transcription. Most epigenetic marks produce differentiation, defining cell and tissue specific function from a common DNA template. Such marks show little inter-individual variation across healthy individuals. However, variation across individuals in the remaining portion of the ‘epigenome’ is highly sensitive to environmental conditions, especially in early development.

Because certain epigenetic marks are highly stable, environmental regulation of the epigenome provides a mechanism for the sustained influence of early experience on gene transcription and brain function. Initial studies of maternal care in the rat documented these effects. Adult offspring of mothers showing increased pup licking/grooming (i.e., High LG mothers) show more modest behavioral and neuroendocrine responses to stress that associates with maternally-regulated differences in glucocorticoid receptor (GR) expression in the hippocampus. Maternal effects on the methylation of the GR gene underlie the difference in expression. Maternal effects on DNA methylation and gene expression occur in genes implicated in synaptic plasticity, learning and memory, fear, and, in the female offspring, maternal behavior. High LG mothers’ offspring show modest stress responses, improved episodic learning and memory; female offspring become High LG mothers with their own offspring. These and similar findings associated with early experience reveal the capacity of the genome to support multiple phenotypic outcomes in response to environmental conditions.

In contrast, the offspring of Low LG mothers show increased stress responses, including greater fearfulness and endocrine activity. They demonstrate increased immunological and glucocorticoid responses to infection which protects Low LG offspring from sepsis. Likewise, under stressful conditions (e.g., contextual fear conditioning), these animals show improved learning and memory. In sum, rearing with Low LG mothers does not ‘impair’ development. Rather the offspring of Low LG mothers grow to be developmentally well-suited for life in stressful conditions with persistent threats and greater risk for infection. Thus, maternal care – their licking frequency—may enhance the ‘match’ between phenotype and environmental demand. Importantly, exposure to chronic stress decreases the frequency of maternal licking/grooming, promoting forms of parental care that enhance survival in offspring under conditions of persistent adversity. The cost is that of increased vulnerability for a range of chronic health conditions. We suggest that such contextual influences on development are a common feature of biology that epigenetic mechanisms subserve.

Translational studies, including those using post-mortem human brains, reveal evidence for environmental regulation of the epigenome. Many studies focused on the GR gene. A systematic review of epigenetic studies with various human tissues revealed associations between multiple forms of perinatal adversity, including childhood maltreatment, and the epigenetic state of the GR gene.

Yehuda’s team linked posttraumatic stress disorder (PTSD) to GR signaling. PTSD symptom severity is associated
with the DNA methylation state of the GR gene. Prospective studies show GR gene polymorphism predicts PTSD status following deployment among military personnel. These studies provide some initial support for the idea that epigenetic signals could predict risk. Methylation of the same GR gene region is also associated with activation of the ventrolateral prefrontal cortex during cognitive testing, consistent with analyses that implicate this region in PTSD. The importance of glucocorticoids in regulating memory under conditions of emotional arousal is an attractive explanation for the relation between GR signaling and PTSD. A functional GR gene polymorphism associates with variation in glucocorticoid-sensitive emotional memory.

The environmental influence on inter-individual variation in epigenetic signals is not limited to the GR gene. Genome-wide analyses reveal environmentally-regulated variation across the genome, particularly in association with transcription factor binding sites. Such localization is interesting, since these genomic regions respond to environmentally-regulated transcription factor signals that regulate gene expression. Nor is variation across the epigenome necessarily linked solely to environmental conditions. Extensive genome-wide analyses reveal that methylation status at sites that show significant inter-individual variation is best explained by gene-environment interactions. Epigenetic marks, like any measure of phenotype, reflect gene-environment interactions.

The peripubertal peak in the onset of common mental disorders presents a significant challenge for prevention. High-risk individuals must be effectively identified in childhood. Neither genetic variation, including integrated measures of genetic risk (e.g., polygenic risk scores) nor environmental conditions alone adequately predict the risk for psychopathology. Instead vulnerability emerges as a function of the interaction between genetic influences that enhance environmental sensitivity and childhood adversity. Therein lies a potential contribution from epigenetic studies. Epigenetic variation reflects gene-environment interaction, including environmental conditions that predict the later risk for mental disorders. The Binder team provides an elegant example of how variation in DNA methylation at the FKBP5 promoter is defined by gene-environment interactions involving an FKBP5 variant genetic variants. Li et al (2013) showed that antenatal maternal anxiety, which predicts childhood socio-emotional problems, associates with DNA methylation states across the genome at birth. The association between antenatal maternal anxiety and inter-individual variation in DNA methylation is moderated by the bdnf genotype of the child, but not the mother (precluding a main effect of genetic transmission). Children bearing the met/met allelic variant of the bdnf gene show a significantly greater effect of maternal anxiety on DNA methylation than those with the Val/Val variant. The met/met genotype is associated with an increased risk for anxiety disorders.

These findings suggest that inter-individual variation in epigenetic marks in early development may reflect the interaction between genetic variation that defines differential susceptibility and clinically-relevant environmental conditions. The relevant epigenetic analyses can be performed with readily accessible peripheral cells. The complex developmental processes that produce epigenetic variation might thus provide a useful reflection of those that lie at the origin of individual differences in vulnerability for psychopathology – and thus identify high risk individuals in early life. ■

References

Dr. Meaney is a James McGill Professor of Psychiatry at McGill University where he is the Director of the Sackler Program for Epigenetics & Psychobiology. He is also Director of the Translational Neuroscience Program at the Singapore Institute for Clinical Sciences. His research programs involve basic models of developmental neurobiology as well as longitudinal, human cohort studies. He was trained in Clinical Psychology and Behavioral Neuroscience (Concordia University) as well as Molecular Neurobiology (The Rockefeller University). He may be reached at michael.meaney@mcgill.ca.
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Register for AACAP’s 65th Annual Meeting Starting in August!

Registration for the Annual Meeting will open on August 1 for AACAP members and August 8 for non-members. Be sure to register early to secure all of your preferred events. Register online in at www.aacap.org/AnnualMeeting-2018.

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You can count on AACAP to provide the latest research in child and adolescent psychiatry with a wide variety of programs to meet all of your educational needs. Get up to date on all of the changes in the field, including psychopharmacology, opioid and marijuana use, wellness and prevention, gender issues, cultural diversity, treating refugees, and interacting with the media. Plus, earn up to 50 CME credits! Check AACAP’s Annual Meeting website for a complete list of programs and speakers.

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Join us at our “Meet the Author” booth in the Exhibit Hall. Sign up for a one-hour time slot to promote your book. We include a 50-word description on a flyer distributed to all attendees as well as a listing in the Annual Meeting Program Book. Limited time slots are available beginning on Wednesday, October 24 and ending on Friday, October 26.

Each one-hour time slot costs:
- $300 per hour (through September 14)
- $350 per hour (through October 5)
- $400 per hour (through onsite)

Be the first author to sign up!

More information can be found at: www.aacap.org/exhibits-2018. Questions? Please contact meetings@aacap.org.
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Registration opens August 1 for AACAP members and August 8 for non-members.

Become a member TODAY to get priority monitor scheduling!

Don’t miss this opportunity to SAVE money!

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 65th Annual Meeting registration. All referrals must be first-time AACAP exhibitors and must purchase a booth for AACAP’s 65th Annual Meeting in Seattle.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals, as well as advertise in several of the Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review the Invitation to Exhibit with more details on these opportunities, as well as forms to sign up, please visit www.aacap.org/exhibits-2018.

Show your support for AACAP and SAVE today!

Questions? Email exhibits@aacap.org or call 202.966.9574.
Hotels

Make your hotel reservations today! Please visit the Annual Meeting website (www.aacap.org/annualmeeting-2018) for more information plus links to the online hotel reservations. The deadline to make your discounted reservations is October 1, 2018, but please do not wait – we expect to sell out of rooms quickly!

Sheraton Seattle Hotel
1400 6th Ave
Seattle, WA 98101
Phone: 206.621.9000
Phone for Reservations: 800.325.3535 or 206.621.9000
Online Sheraton Reservations
Traditional Rooms (lower floor): $239 single/double per night
Deluxe Rooms (higher floor): $249 single/double per night

The Sheraton Seattle Hotel is the headquarter hotel for the Annual Meeting and hosts a portion of the educational sessions and committee meetings. Located just one block from the Convention Center, the Sheraton is in the center of downtown Seattle, a short walk away from many attractions.

Hyatt at Olive 8
1635 8th Avenue
Seattle, WA 98101
Phone: 206.695.1234
Online Hyatt Olive 8 Reservations
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Located 2 blocks from the Convention Center, the Hyatt at Olive 8 hotel is famous for its deep environmental commitment and offers an incredible selection of modern amenities designed to make your stay remarkable and keep the city green.

Grand Hyatt Seattle
721 Pine Street
Seattle, WA 98101
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Online Grand Hyatt Reservations
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Located across the street from the Convention Center, the Grand Hyatt Seattle Hotel offers a luxurious urban retreat with incredible amenities and services designed to make your stay remarkable.

The Paramount Hotel
724 Pine Street
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Online Paramount Hotel Reservations
Rates: $190 single/double per night

Located two blocks from the Convention Center, the Paramount Hotel summons the feel of a cozy, elegant, and luxurious private residence with friendly hosts, the most comfortable beds in Seattle and an award-winning Asian restaurant right downstairs.
Helen Beiser, MD, Art Show

Join us at the annual Helen Beiser, MD, Art Show in the Exhibit Hall in Seattle!

Coordinated through AACAP’s Local Arrangements Committee and Art Committee, we invite creative AACAP members and their family to submit artwork to make this year’s show spectacular! You may exhibit up to three pieces of art. We are looking for original works including paintings, drawings, illustrations, potteries, sculptures, calligraphy, poetry, letterpress broadsides, artist’s books, and photographs. The Art Show, open October 24-26, is for exhibition purposes only – no pieces are offered for sale.

As well, all artists are welcomed and encouraged to participate in “Meet the Artists” in the Exhibit Hall on Thursday, October 25, from 3:00-4:00pm. This event will give you the chance to showcase your art first hand to the Annual Meeting Attendees. Don’t miss out on this exciting opportunity!

For more information, please contact exhibits@aacap.org.

To submit an artwork application, please register and submit artworks online at aacap.wufoo.com/forms/ragm1lh1ntysan.
As part of an ongoing Call for Papers, JAACAP seeks high-impact papers on the mental health of children, adolescents, and families with a particular interest in our new article types for 2018, including Master Clinician Reviews, Commentaries, and Case Conferences.

Special Call for Papers on Depression

In conjunction with the presidential initiative of AACAP President Karen Dineen Wagner, MD, PhD, on depression, JAACAP and JAACAP Connect have issued a special call for papers on this timely topic. The series aims to cover current topics in depression, including but not limited to programs that have initiated depression screening for youth and processes by which youth who screen positive for depression receive treatment.

Call for Cover Artwork

JAACAP seeks interesting images and original artwork by children and youth, including but not limited to those who have personally struggled with mental health challenges. Submissions in which the artist reflects upon their identity, family, and/or community are particularly encouraged.

Questions and pre-submission inquiries should be directed to support@jaacap.org or connect@jaacap.org.
Letter to the Editor: Clinical Benefits of Pharmacogenomic Testing

I appreciate the articles in the May/June AACAP News on pharmacogenomics (PGx). Contrary to the recommendations of those articles, I have found significant usefulness in PGx testing to optimize drug therapy on a personalized level.

By way of introduction, I have been in practice since 1981. For the past 16 years, I was in solo private practice. I currently work for two residential treatment facilities for teenagers.

Over the last eight years, I ordered PGx testing on over 250 patients in collaboration with three different companies. Only the third company provided the results in a helpful format. Of those 250 patients, none had completely “normal” results.

One example is of a very intelligent, 14-year-old African American boy who was adopted in infancy. His diagnoses are attention-deficit/hyperactivity disorder (ADHD), combined type, severe, obsessive-compulsive disorder (OCD), and chronic posttraumatic stress disorder (PTSD). He lives in a residential treatment facility where he receives his medications reliably. Highly experienced staff provide valuable behavioral and emotional observations. Upon entering the facility, this patient’s adoptive mother cautioned me about using medications because of multiple previous treatment failures. This gave rise to my request for PGx testing. The results are summarized in Table 1. Being a poor metabolizer at 2D6 and 2B6 and an intermediate metabolizer at 3A4 and 2C19 significantly complicates usual outpatient medication management.

Over the course of a year, the patient’s ADHD symptoms were brought under reasonable control with mixed amphetamine salts 7.5 mg q AM and 5 mg q noon, guanfacine ER 6 mg q 3:00 pm and atomoxetine 18 mg q am. He complained that his OCD tormented him because of his need to rewrite letters in words until they “felt” right. The treatment program requires the boys to do considerable written work. Using the PGx results for guidance, I added Prozac 5 mg once a week. Both he and staff observed benefits from this small dose. Arriving at this combination of medications relied heavily on the company’s recommendations, not just on the actual results (e.g., choosing Prozac rather than a different SSRI).

Of note, the patient ended up on two “significant gene-drug interaction” medications (red bin), one “moderate gene-drug interaction” medication (yellow bin), and one “no known gene-drug interaction” (green bin). This illustrates the importance of clinicians using specific allele recommendations to guide treatment and not relying on the colors of the bins. “Red bin” medications may actually be ideal for a patient, albeit in unlikely doses.

The significance of these medications for this patient is profound as there were doubts that he would be able to manage in a foster home. His mother was not prepared to have him come home prior to the improvements he showed on the medications, but after seeing improvements, she was now prepared to have him return home.

It is true that PGx cannot identify which medications will be effective, and even though PGx is not helpful for all patients, PGx can identify which medications are more likely to be tolerated. I find I get to an effective medication sooner using PGx results.

Dr. Moreau was employed in a variety of positions after completing her CAP training in 1982. Most recently, she retired from a 17-year solo private practice. She continues to provide psychiatric services for two Residential Treatment Facilities for teenagers and two Child and Adolescent Partial Hospitalization Programs. She may be reached at joanmoreaumd@gmail.com.

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<td>Both alleles suggest normal activity</td>
</tr>
<tr>
<td>CYP2B6</td>
<td>PM</td>
<td>*6/*6</td>
<td>Both alleles suggest reduced activity</td>
</tr>
<tr>
<td>CYP2C19</td>
<td>IM</td>
<td>*1/*2</td>
<td>One allele suggests normal activity, the second suggests no activity</td>
</tr>
<tr>
<td>CYP2C9</td>
<td>EM</td>
<td>*1/*1</td>
<td>Both alleles suggest normal activity</td>
</tr>
<tr>
<td>CYP3A4</td>
<td>IM</td>
<td>*1/*22</td>
<td>One allele suggests normal activity, the second suggests reduced activity</td>
</tr>
<tr>
<td>CYP2D6</td>
<td>PM</td>
<td>*4/*17</td>
<td>One allele suggests no activity, the second suggests reduced activity</td>
</tr>
<tr>
<td>SLC6A4</td>
<td>S/S</td>
<td></td>
<td>This genotype “may have a decreased likelihood of response to some SSRIs.”</td>
</tr>
<tr>
<td>HTR2A</td>
<td>G/A</td>
<td></td>
<td>This genotype is “not indicative of adverse drug reactions with SSRIs.”</td>
</tr>
<tr>
<td>COMT</td>
<td>Val/Met</td>
<td></td>
<td>This genotype is “more likely to have a typical response to stimulant medications.”</td>
</tr>
<tr>
<td>ADRA2A</td>
<td>C/G</td>
<td></td>
<td>“This genotype suggests a typical response to certain ADHD medications.”</td>
</tr>
</tbody>
</table>

*EM-extensive metabolizer, UM-ultrarapid metabolizer, IM-intermediate metabolizer, PM-poor metabolizer, CYP-cytochrome P450 gene.
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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.
Depression Screening: Some Pros and Cons

K aren Dineen Wagner, MD, PhD, in her Presidential Address1 describes the “devastating impact of depression on children’s emotional, social, and cognitive development” and notes that the prevalence rates of depression have been increasing in youth, such that they are now being reported at 11%. She further points out that her “... presidential initiative is to increase awareness of and screening for depression in children and adolescents.” She then argues powerfully in favor of routine screening for depression in adolescents with the use of the Patient Health Questionnaire (PHQ-A). The timing is excellent, as her call for the use of the tool comes close to the time the American Academy of Pediatrics (AAP) announced its policy advocating such screening.

The Pros: In favor of depression screening, Dr. Wagner reminds us of the reported rising rates of depression in adolescents as well as its devastating impact and risk of suicide. She powerfully describes the many resulting problems for the patients and their families.

The Cons: A recent case led me to give serious thought to the question of screening for depression. With some apprehension, I accepted a case which was presented to me as being especially difficult. The case was about a 14-year-old female, who had been discharged a year previously from a month-long hospitalization with the diagnosis of Major Depressive Disorder, complicated by a comorbid mixed eating disorder and self-mutilation. Her referral to me was made in the hope of preventing another hospitalization. The severity of her depression had been supported by her having scored 100% on the Beck Youth Depression Inventory (BDI-Y). With the highest possible score, it seemed that this patient could not be more depressed.

Once I accepted the case and met with the patient and her mother, I reviewed a thick stack of her outpatient and inpatient records for her from age 12, which was over one year prior to her hospitalization. Aside from the notes made by her inpatient psychiatrists and social worker, I determined the following:

1. There was no evidence of in-hospital behaviors consistent with a diagnosis of depressive disorder or self-mutilation.
2. There was no evidence of weight changes or in-hospital behaviors which might reasonably lead to a diagnosis of an eating disorder.
3. None of the in-hospital nurses’ notes and two of the three social workers’ notes were consistent with any of her three current diagnoses.
4. The hospital chart also included printouts of her BDI-Y testing. It was scored to show that my patient was not only severely depressed, but she had clinically significant levels for anxiety and anger; yet, no symptoms of those issues were charted as occurring while she was inpatient. Her only medication was fluoxetine, with its highest dose being 30 mg. Her dose at discharge from the hospital was 10 mg. She had been continued on that dose until she became my patient. Not long after we began working together, the medication was successfully tapered and discontinued without negative consequences.

This led me to research the BDI-Y. With one exception, all the reviews of the BDI-Y which I found spoke positively about the tool, though I did find one article which supported my increasing sense that my patient was much more a sad and protesting adolescent who had found herself in what she had perceived to be an intolerable living situation.

Dr. Wagner, at the end of her Presidential Address, asks us “to join (her) in the effort to raise public awareness of depression in children and...
adolescents and to promote routine screening for depression in youth.” However, she earlier correctly noted that, “The USPSTF found that current evidence is insufficient to assess the balance of benefits and harms of screening for major depressive disorder in children 11 years or younger.”

Regarding the screening of adolescents, Dr. Wagner stated, “The US Preventive Services Task Force (USPSTF) reviewed the evidence on the benefits and harms of depression screening... and the accuracy of screening tests. Based on their review, the USPSTF recommends screening (for adolescents).” What is not mentioned is that it did not get an A, but a B grade, the criteria for which is: “There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.” The decision of two comparable agencies, the Canadian Task Force on Preventive Health Care and the UK National Screening Committee, are also not mentioned. Both recommended against screening.

I suspect a telling difference between the conclusion made in our country and the conclusion of comparable agencies in Canada and the United Kingdom has to do with the United States being one of two countries, with New Zealand as the other country, which allows direct consumer advertising of pharmaceuticals. This suggests that the pharmaceutical industry, which devotes a large proportion of its resources to lobbying, has been successful in influencing our policies with respect to the marketing of medications.

PHQ-9, the depression screening tool recommended by Dr. Wagner and the AAP, was developed by Pfizer, a corporation which makes its money by selling medications, not by assisting us in making diagnoses.

Conclusion: There is no question that Dr. Wagner is correct in advocating for us to be aware of the high human costs associated with major depression. But there is also a high cost to overpathologizing and then medically treating patients of any age for having emotions. We have been trained to diagnose and treat depression as appropriate with a variety of tools, not just pharmaceuticals. Admittedly, it takes more time than a self-administered questionnaire, but I am confident that a better way to screen is to use ourselves in an alliance with our patient and the family. If we are prepared to use our listening skills in the course of a respectful, empathic, comprehensive evaluation, we will get a much superior product. By the end of listening, taking a history, establishing contacts with collateral sources, we should have a strong working relationship with our patient and the patient’s family. The positives which flow out of that process include a richer understanding of the patient, a more accurate diagnosis, a more workable treatment plan, and better treatment compliance.

References
1. Wagner KD. President’s Address: Depression Awareness and Screening in Children and Adolescents. AACAP News 49:5-7.

Dr. Levin is a Distinguished Life Fellow of AACAP. He practices in Berkeley, California. He may be reached at eclevin@earthlink.net.

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Your donations have made this achievement possible. We are in the midst of a mental health crisis, which comes at a time when our skills have never been more important. Yet, the deficit of available child and adolescent psychiatrists is widening. Life Members are closing this gap. Let’s keep it up.

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Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.
AACAP’s 2018 Legislative Conference Wrap-Up

On April 8-9, 2018, AACAP held its annual Legislative Conference. Nearly 250 AACAP members and family advocates from 36 states came to Washington, DC, to advocate for medical student debt loan relief for child and adolescent psychiatrist training fellows and more mental health resources for our nation’s schools. All told, AACAP members and family advocates visited over 180 Congressional offices.

The conference kicked off on Sunday afternoon with an “Introduction to Key Issues and Politics” segment. This session allowed attendees to learn the details of what was occurring on Capitol Hill and what to expect in their Congressional meetings. On Monday morning, attendees convened one last time for “issue training” before meeting with their Members of Congress on Capitol Hill. AACAP would especially like to thank the members of our Advocacy Committee who helped with the planning and training at this year’s Legislative Conference, including the committee’s co-chairs, Debra Koss, MD, and Karen Pierce, MD, for their inspirational leadership.

Thanks to the excellent advocacy work by AACAP members and families, dozens of new House and Senate co-sponsors have been added to two critical bills: “Ensuring Children’s Access to Specialty Care Act” and the “Mental Health in Schools Act.” Grassroots advocacy works, and your voices are generating more support daily!

AACAP also awarded its prestigious “Friends of Children’s Mental Health” award to three wonderful Congressional champions of children’s mental health: Reps. Grace Napolitano (D-CA), John Katko (R-NY), and Don Beyer Jr. (D-VA).

AACAP’s Legislative Conference once again proved what AACAP members and family advocates can achieve when they advocate together. Please save the date for AACAP’s 2019 Legislative Conference, May 2-3, 2019, in Washington, DC.

Michael Linskey is AACAP’s Deputy Director of Congressional & Political Affairs. He may be reached at mlinskey@aacap.org.
From a Family Advocate’s Viewpoint

My name is Paula. I work with elderly clients who have dementia. So, why was I advocating with the American Association of Child and Adolescent Psychiatry?

In my time with elderly clients, I have noticed that even as they lose access to their most precious memories, they often strongly remember childhood traumas. Events that happen in their formative years between infancy and adulthood affect them throughout their lives. I am here to tell my story because—I like my clients—I am still trying to deal with what happened to me in my childhood.

I grew up in a remote, rural area. From elementary into high school, some of my peers bullied me. As a result, I endured depression and anxiety. My older brother suffered from mental illness and underwent a major crisis event when I was in high school. My parents were overwhelmed, and the stigma associated with mental illness kept me from talking to others about what my family was going through.

I finally confided in a teacher I trusted, only to later realize that he had been grooming me for sexual assault. There were no mental health professionals within the schools who might have recognized the symptoms and helped me. Only one friend among my classmates recognized my “symptoms.” There were no child or adolescent psychiatrists nearby; even if there had been one, my family had no money to pay for treatment. After I graduated, I gathered all the courage my 17-year-old self had to meet with and confide in my principal and three other teachers. I did not want what I experienced to happen to anyone else.

I am 51 years old. My childhood trauma story began long ago. I am here because I do not see that a lot has changed, and that bothers me. As an AACAP family advocate, I ask our government representatives to sponsor specific legislation to help address our national scarcity of child and adolescent psychiatrists, and to expand nationwide a successful pilot program that puts mental health professionals into schools.

- Please co-sponsor and advance H.R. 3767 or S. 989, “Ensuring Children’s Access to Specialty Care Act of 2017,” introduced by Reps. Long (R-MO) and Courtney (D-RI) and Sens. Roy Blunt (R-MO) and Jack Reed (D-RI) to include pediatric subspecialists in the NHSC loan relief program through technical corrections.

- Please co-sponsor and advance H.R. 2913 “The Mental Health in Schools Act of 2017,” as introduced by Reps. Grace Napolitano (D-CA) and John Katko (R-NY).

I am grateful that AACAP allowed me this opportunity to use my voice and experiences to help future and present-day children and adolescents. We must do all we can to reduce the stigma and to support the mental health of all of our children. Traumatized children grow into traumatized adults, and, if we are lucky enough to become elderly, it would be a gift for us to not continue to have nightmares. Thank you.

Paula Wilks-Wright is a certified respite caregiver for families whose loved ones struggle with Alzheimer’s or other dementias. Her passion is promoting empathy in people of all ages. She may be reached at pwilkswright@att.net.
LEGISLATIVE WRAP-UP
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.
Congratulations to Graduating Residents and Medical Students

Please provide us with your updated contact information after graduation.

You can update your information online at www.aacap.org.

This Could Be Your Last Issue!

Renewed for 2018? If not, you could be holding your last issue of AACAP News!

Logon to www.aacap.org and renew today. Contact Member Services at 202.966.7300, ext. 2004 to renew by phone.
Welcome New AACAP Members

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Manar Abdelmeged, MD, Kansas City, MO
Ayodola A. Adigun, MD, Brooklyn, NY
Kelsey Adler, Iowa City, IA
Bilal Ahmad, MD, Baton Rouge, LA
Jafreen Ahmed, MD, Lubbock, TX
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Kamal Al-Shalby, Ann Arbor, MI
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John Wubbenhorst, DO, Blue Springs, MO
Jiwon Helen Wyman, MD, San Francisco, CA
Zhong Ye-Bates, MD, Gainesville, FL
Sarah Zheng, MD, San Francisco, CA
AACAP AWARD SPOTLIGHT:
Jeffrey R. Strawn, MD

2009 AACAP Pilot Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows
Project Title: Neurophysiology and neurochemistry of generalized anxiety disorder in adolescents

2012 AACAP Pilot Research Award for Attention Disorders, supported by the Elaine Schlosser Lewis Fund
Project Title: The neurophysiologic impact of anxiety on attentional processing in adolescents with ADHD

These awards allowed me to embark on projects related to the neurophysiology, neurochemistry and neuroanatomy of anxiety disorders in children and adolescents. Funding from these AACAP Pilot Awards supported our examinations of cortical thickness, gray matter volumes and functional activity in anxious adolescents. This work revealed abnormal cortical thickness in an ensemble of regions responsible for fear learning, fear extinction, reflective functioning (e.g., mentalization), and regulation of the amygdala. We also observed that glutamate in the anterior cingulate cortex is directly linked with anxiety severity in youth. Taken together, this body of work propelled additional studies—with great collaborators—that focus on these structures in youth who are at risk for developing anxiety disorders and studies that integrate treatment and neuroimaging in anxious youth. Additionally, data generated from these AACAP awards provided a scaffold for work that disentangled the neurophysiologic impact of co-occurring conditions on the neurocircuitry of anxiety disorders. In this regard, we have examined the impact of co-occurring anxiety in youth with major depressive disorder on gray matter volumes. Our findings suggested that gray matter deficits in specific regions in youth with anxious depression compared to patients with major depressive disorder and no anxiety may reflect the more severe psychopathology in these patients. Finally, based on the early support from these AACAP awards, we are now examining several important psychological factors including attachment style and reflective functioning with regard to specific neurostructural and neurofunctional fingerprints in anxious youth that may have implications for psychotherapeutic treatment in these patients.

ABOUT DR. STRAWN

JOINED AACAP: FEBRUARY 2008
WORKS AT: UNIVERSITY OF CINCINNATI
POSITION: ASSOCIATE PROFESSOR OF PSYCHIATRY & PEDIATRICS; DIRECTOR, ANXIETY DISORDERS RESEARCH PROGRAM
INTERESTS: PEDIATRIC ANXIETY DISORDERS; NEUROIMAGING
AACAP AFFILIATIONS: PSYCHOTHERAPY COMMITTEE (CO-CHAIR)
PROGRAM COMMITTEE (INSTITUTES SUB-COMMITTEE CHAIR)
2014, 2015, 2018 SUMMER MEDICAL STUDENT FELLOWSHIP MENTOR
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- Paula Marie Smith, MD

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Get in the News!

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- **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* (JAACAP). 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.

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**Lifelong Learning Module 12 Expires August 31, 2018**

AACAP’s Lifelong Learning Module 12: *Relevant Clinical Updates for Child and Adolescent Psychiatrists* expires on August 31, 2018. Be sure to complete your module exams before the deadline to earn a total of 38 AMA PRA Category 1 Credits™ (8 of which can be used towards the ABPN’s self-assessment requirement).

If you currently have Module 12, complete your exams online before August 31st to receive credit (complete instructions are included within your module). **Exams cannot be submitted for grading after August 31st.**
Marijuana and Teens

Many teenagers try marijuana and some use it regularly. Teenage marijuana use is at its highest level in 30 years, and today’s teens are more likely to use marijuana than tobacco. Many states allow recreational use of marijuana in adults ages 21 and over. Recreational marijuana use by children and teenagers is not legal in anywhere in the United States. Today’s marijuana plants are grown differently than in the past and can contain two to three times more tetrahydrocannabinol (THC), the ingredient that makes people high. The ingredient of the marijuana plant thought to have most medical benefits, cannabidiol (CBD), has not increased and remains at about 1%.

There are many ways people can use marijuana. This can make it harder for parents to watch for use in their child. These include:

- Smoking the dried plant (buds and flowers) in a rolled cigarette (joint), pipe, or bong
- Smoking liquid or wax marijuana in an electronic cigarette, also known as vaping
- Eating “edibles” which are baked goods and candies containing marijuana products
- Drinking beverages containing marijuana products
- Using oils and tinctures that can be applied to the skin

Other names used to describe marijuana include weed, pot, spliffs, or the name of the strain of the plant. There are also synthetic (man-made) marijuana-like drugs such as “K2” and “Spice.” These drugs are different from marijuana and are more dangerous.

Parents and Prevention

Parents can help their children learn about the harmful effects of marijuana use. Talking to your children about marijuana at an early age can help them make better choices and may prevent them from developing a problem with marijuana use later. Begin talking with your child in an honest and open way when they are in late elementary and early middle school. Youth are less likely to try marijuana if they can ask parents for help and know exactly how their parents feel about drug use.

Tips on discussing marijuana with your child:

- Ask what they have heard about using marijuana. Listen carefully, pay attention, and try not to interrupt. Avoid making negative or angry comments.
- Offer your child facts about the risks and consequences of smoking marijuana.
- Ask your child to give examples of the effects of marijuana. This will help you make sure that your child understands what you talked about.
- If you choose to talk to your child about your own experiences with drugs, be honest about why you used and the pressures that contributed to your use. Be careful not to minimize the dangers of marijuana or other drugs, and be open about any negative experiences you may have had. Given how much stronger marijuana is today, its effect on your child would likely be much different than what you experienced.
- Explain that research tells us that the brain continues to mature into the 20s. While it is developing, there is greater risk of harm from marijuana use.
Sometimes parents may suspect that their child is already using marijuana. The following are common signs of marijuana use:

- Acting very silly and out of character for no reason
- Using new words and phrases like “sparking up,” “420,” “dabbing,” and “shatter”
- Having increased irritability
- Losing interest in and motivation to do usual activities.
- Spending time with peers that use marijuana
- Having trouble remembering things that just happened
- Carrying pipes, lighters, vape pens, or rolling papers
- Coming home with red eyes and/or urges to eat outside of usual mealtimes
- Stealing money or having money that cannot be accounted for

**Effects of Marijuana**

Many teenagers believe that marijuana is safer than alcohol or other drugs. When talking about marijuana with your child, it is helpful to know the myths and the facts. For example, teenagers may say, “it is harmless because it is natural,” “it is not addictive,” or “it does not affect my thinking or my grades.”

However, research shows that marijuana can cause serious problems with learning, feelings, and health.

**Short-term use of marijuana can lead to:**

- School difficulties
- Problems with memory and concentration
- Increased aggression
- Car accidents
- Use of other drugs or alcohol
- Risky sexual behaviors
- Worsening of underlying mental health conditions including mood changes and suicidal thinking
- Increased risk of psychosis
- Interference with prescribed medication

Regular use of marijuana can lead to significant problems including Cannabis Use Disorder. Signs that your child has developed Cannabis Use Disorder include using marijuana more often than intended, having cravings, or when using interferes with other activities. If someone with Cannabis Use Disorder stops using suddenly, they may suffer from withdrawal symptoms that, while not dangerous, can cause irritability, anxiety, and changes in mood, sleep, and appetite.

**Long-term use of marijuana can lead to:**

- Cannabis Use Disorder
- The same breathing problems as smoking cigarettes (coughing, wheezing, trouble with physical activity, and lung cancer)
- Decreased motivation or interest which can lead to decline in academic or occupational performance
- Lower intelligence
- Mental health problems, such as schizophrenia, depression, anxiety, anger, irritability, moodiness, and risk of suicide

**Medical Marijuana**

Some teens justify use of marijuana because it is used for medical purposes. Marijuana use with a prescription for a medical reason is called “medical marijuana.” Laws for medical marijuana are rapidly changing and are different from state to state. In some states, children of any age can get medical marijuana if they have a “qualifying medical condition.” There is very limited research supporting use of medical marijuana in children or teens for most conditions. In most states that allow medical marijuana, the marijuana is not regulated and therefore is not checked for ingredients, purity, strength or safety. There is no evidence that medical marijuana is any safer than other marijuana.
Conclusion

Marijuana use in teens can lead to long-term consequences. Teens rarely think they will end up with problems related to marijuana use, so it is important to begin talking about the risks with your child early and continue this discussion over time. Talking with your child about marijuana can help delay the age of first use and help protect their brain. If your child is already using marijuana, try asking questions in an open and curious way as your teen will talk more freely if not feeling judged. If you have concerns about your child’s drug use, talk with your child’s pediatrician or a qualified mental health professional.

Related Resources:

For more information about marijuana, drugs, and teenagers, you can check out:

- AACAP Policy statement on Marijuana Legalization
- AACAP Policy Statement on Medical Marijuana

National Institute on Drug Abuse (NIDA)

- Information for Parents About Marijuana
- Information About Marijuana
- Marijuana Facts for Teens

# # #

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AACAP Policy Statement

American Academy of Child and Adolescent Psychiatry

Separating Immigrant Children From Their Families

Approved by Council June 2018

The American Academy of Child and Adolescent Psychiatry (AACAP), a medical association representing physicians dedicated to the health of children and families around the globe, advocates putting an end to the practice of separating immigrant children from their families.

As child and adolescent psychiatrists, we recognize that parental support is an essential and proven factor for protecting children and helping children recover from the negative impacts of stress and trauma (1, 2). Maternal support has been shown to strengthen neuroprotective factors in the brain during childhood, when children’s brains are most vulnerable (3). Separating children from their families in times of stress can place children at heightened and unnecessary risk for developing potentially serious and long-lasting traumatic stress reactions, at the very time when they are most in need of care and support.

In addition, we know that pulling families apart can cause harm. When children experience sudden separation from one or both parents, especially under frightening, unpredictable, and/or chaotic circumstances, they are at heightened risk for developing posttraumatic stress disorder (PTSD), anxiety, depression, and other trauma-related reactions that may last for the rest of their lives. This is especially the case for children who are fleeing war, violence, or other traumatic situations in their home countries, since these children are already pre-disposed to developing trauma-related reactions.

Based on our expertise as physicians who focus on the mental health of children:

- AACAP opposes policies that attempt to deter immigration by separating children from their parents. Separation places already vulnerable children at increased risk for traumatic stress reactions, psychiatric disorders, and other adverse medical outcomes.
- AACAP supports using the appropriate official agency, in this case child protective services, as the pathway to conduct a thorough investigation and document any child abuse or neglect requiring the child’s removal from the parent or caregiver before children and families are separated.
- AACAP advocates for the provision of developmentally, culturally, and linguistically appropriate, trauma-informed services for children and families, including the availability of evidence-based, trauma-focused treatment for children who develop significant trauma responses (4).

References:


For more information or to review AACAP’s Policy Statements visit www.aacap.org.
CALIFORNIA

ADULT AND CHILD PSYCHIATRISTS
(Riverside, CA)

Job Description:
ADULT AND CHILD PSYCHIATRISTS
Openings in Riverside, California
At the Southern California Permanente Medical Group (SCPMG), we believe in giving every member of our community the opportunity to live a happy, healthy life. From the physicians we employ to the patients we serve, our mission is to provide a level of care and support that enables each of us to achieve our best. Riverside is an area rich in recreational opportunities. Here, you can enjoy world class golf and tennis facilities, Lake Matthews, the Box Springs Mountain and the Mount Rubidoux Trail. You’ll also enjoy our many cultural attractions, including the Riverside Metropolitan Museum, Mission Inn, Fox Performing Arts Center, Coachella Valley Music and Arts Festival and more. And our location is ideal, as just about 2 hours can take you from Palm Springs to San Diego to the beach. At SCPMG, you’ll enjoy the amazing recreational activities, spectacular natural scenery and exceptional climate our area is known for, along with stability in today’s rapidly changing health care environment. SCPMG is proud to offer its physicians: 4 1/2 day work week (8-10 hours) Options for flexible schedules Education time (1/2 day a week) Multi-disciplinary team approach - MA, LCSW, Psychologists Medical, Dental, Vision, Life and Supplemental Comprehensive Insurance Robust retirement plan: Define Pension Plan, 401K and Keogh Excellent salary and compensation package (bonuses offered) Partnership after 3 years. If you believe in pursuing dreams, creating hope and driving progress, then you’re the very definition of a Permanente Physician.

For consideration or to apply, please visit our website at http://scpmgphysiciancareers.com.

For questions or additional information, please contact Jolanta Buschini at (877) 259-1128 or Jolanta.U.Buschini@kp.org.

The Answer to Health Care in America.
Company: Spin Recruitment Advertising (876472)
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http://jobsource.aacap.org/jobs/11106183

PSYCHIATRIST, ADULT AND CHILD
Antelope Valley, California

Job Description:
ADULT AND CHILD PSYCHIATRISTS
Openings in Antelope Valley, California
Every physician who is part of the Southern California Permanente Medical Group shares a passion for advancing the practice of medicine. We fuel that passion by creating a culture of innovation and collaboration—one where the quality of care we deliver is elevated by the accelerated resources we provide. Our Antelope Valley location offers spectacular natural scenery and offers four distinct seasons. Ideally located a 1-2 hour drive from beaches, skiing, Hollywood and Downtown LA, you’re also just a short trip away from amazing recreational activities such as hiking, skiing and watersports. We also provide an excellent salary/benefits package and stability in today’s rapidly changing health care environment. Our Psychiatry Department is medium-sized offering all of us an opportunity to get to know each other very well. It also allows for individuals to take their own initiative and start new programs or create solutions, and provides for greater flexibility of schedules. Our physicians enjoy: 4 1/2 day work week (8-10 hours) Options for flexible schedules Education time (1/2 day a week) Multi-disciplinary team approach - MA, LCSW, Psychologists Opportunity to work in a robust Autism program Opportunity to work in an Addiction Medicine department if desired On-call at local hospital with opportunity to work both in-patient and consult/Liaison Medical, Dental, Vision, Life and Supplemental Comprehensive Insurance Robust retirement plan: Define Pension Plan, 401K and Keogh Excellent salary and compensation package (bonuses offered) Partnership after 3 years. If this sounds like the ideal working environment for you, then you’re the very definition of a Permanente Physician. Consider joining us today.
For consideration or to apply, please visit our website at http://scpmsgphysiciancareers.com.

For questions or additional information, please contact Jolanta Buschini at (877) 259-1128 or Jolanta.U.Buschini@kp.org.
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PSYCHIATRISTS, ADULT, ADOLESCENT AND CHILD
Kern County, California

Job Description:
COME HOME TO SOUTHERN CENTRAL CALIFORNIA
ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
Kern County, California
Competitive Salary and Excellent Benefits plus GENEROUS BONUS.
In addition to a picturesque location in Central California’s recreational heartland, the Southern California Permanente Medical Group is proud to offer its physicians: A fully integrated, multi-specialty health care delivery group serving Southern California for over 70 years which offers a stable practice during an ever-changing, uncertain health care climate A physician-led medical practice, affording professional autonomy and convenient cross-specialty collaboration Comprehensive administrative support A clinical environment that promotes evidence-based, excellent patient care services A highly efficient electronic medical record system with convenient remote access Partnership eligibility after 3 years.
MEDICAL EDUCATION LOAN REPAYMENT PROGRAM. The Program offers up to $170,000. Ask about our Medical Education Loan Repayment Program and Advance on Pay Bonus.

For consideration or to apply, please visit our website at http://scpmsgphysiciancareers.com.

GEORGIA

MEDICAL DIRECTOR – CHILDREN’S BEHAVIORAL HEALTH
(Kenneway, GA)

Job Description:
Are you a confident visionary leader who is passionate about residential care and family engagement? Are you looking to lead a dynamic multi-disciplinary team? Then consider joining our Devereux Advanced Behavioral Health Team! Being a Medical Director at Devereux has its AdvantagesYou will work with other dedicated professionals who share your passion for helping individuals in need. What will this opportunity offer you? - The support of a national organization in implementing evidence-based treatment programs, and the support of campus leadership in creating a vision to improve the quality of care for our youth. - Oversee the conversion of our girls program into a full DBT program, which will involve 18 months of training and consultation. - As a participant in the SAMHSA grant to address polypharmacy in the residential setting, this role will monitor and reduce polypharmacy whenever possible, by ensuring that staff members have the skills they need to understand and manage problem behaviors. - Continue implementing Devereux positive behavior Interventions and Supports throughout our campus and continue to use it as our foundation for shaping and rewarding positive behaviors. - Access to Devereux’s Institute of Clinical Practice, Training and Research, and memberships to professional organizations and conferences. Devereux Advanced Behavioral Health Georgia is a 100-bed residential facility located on a 40-acre campus in Kennesaw, Georgia, providing services to youth ages 10-21 years. We offer a broad range of educational and evidence-based treatments in a nurturing environment using positive behavior interventions and support. Our current treatment tracks include; Trauma Focused Cognitive Behavioral Therapy

continued on page 222
and employment programs and services that positively impact the lives of tens of thousands of children, adults and their families every year. Competitive Salary and Benefits In addition to a competitive salary, Devereux Advanced Behavioral Health provides a comprehensive health and wellness program to eligible full-time employees, family members and domestic partners. Our health and wellness programs include medical, dental, prescription drug, preventative care, mental health services and an employee assistance / work-life balance program. In addition, we offer generous time-off policies and a 403(b) retirement plan, along with voluntary/employee paid vision, supplemental life and accident coverage to full-time employees. Learn Why We Are a Great Place to Work! http://benefits.devereux.org. Keywords: psychiatrist, child, adolescent, CAP, MD, medical services director, medical director, child psychiatry, residential treatment, inpatient, outpatient, mental health, AACAP, GGPA

Job Requirements:
Our Ideal Candidate:
- Board Certified or Board-Eligible Child and Adolescent Psychiatrist with current Georgia license. Completion of an approved psychiatric residency program. - Three (3) years experience in child and adolescent psychiatry with one (1) year experience in an administrative role preferred. Must demonstrate relevant treatment competency through clinical experience, continuing education units and referral letters to support these specific skills. - Ability to collaborate, lead teams, provide direction and integrate inter-disciplinary treatment approach. - Ability to balance leadership/administrative and direct client care (50%).

Company: Devereux Advanced Behavioral Health (1101841)
Job ID: 1092393
http://jobsource.aacap.org/jobs/11092393

NEW JERSEY
LUCRATIVE OUTPATIENT OPPORTUNITIES IN NJ FOR CHILD PSYCHIATRIST AND FOR ADULT PSYCHIATRIST (Cedar Knolls, NJ)

Job Description:
ADHD, Mood and Behavior Center is in search of the right board certified or eligible child psychiatrist and adult psychiatrist to join our private, award-winning, multi-disciplinary, state-of-the-art outpatient psychiatric evaluation and treatment center, in Cedar Knolls, New Jersey. Both these candidates will join our team of child, adolescent and adult psychiatrists, psychologists, psychotherapists, executive coaches and learning consultants, providing the exceptional level of care that our Center is widely known for and that our clinicians have received awards and high honors for. Responsibilities will include performing psychiatric evaluations, psychopharmacologic treatment and, if desired, psychotherapy, for the children, adolescents, young adults, families and adults referred to our Center. The adult psychiatry candidate must also be comfortable treating adolescents, as well. A strong administrative staff is always present to open and close the Center daily; greet our patients and their families; provide for all the clinicians’ administrative and clerical needs, including managing all scheduling, payments, chart maintenance, making calls to patients, pharmacies, collaborating physicians and therapists; managing all incoming and outgoing messages, prior authorizations and letters and reports, and more. The Center’s new psychiatrists will practice in spacious professional offices, in our modern outpatient Center, in a luxurious office building, with abundant parking availability. Our Center is situated in an affluent area of northern New Jersey, adjacent to Morristown, less than an hour by car or train from NYC, and easily accessible from several major thoroughfares. This offer is for the serious candidate who shares our philosophy of excellence in patient care and our business model of generous reward for productivity. Qualified, interested candidates looking to join a cohesive group of highly trained professionals, providing high quality care and receiving the highest in financial compensation, should contact the Center, with
hospitalists and community pediatricians. The facility has a medical staff that is made up of pediatricians, pediatric surgeons, and trauma services. Our state of the art Children's Emergency Department is one of the safest, most responsive care is delivered. The Children's Emergency Department provides coverage in-house to ensure the safe, most responsive care is delivered. Additionally, there is a child and adolescent acute inpatient psychiatric unit at the Unity Center for Behavioral Health, which is a community collaboration of four healthcare systems within the Portland metro area. Randall Children's Hospital is a teaching facility for medical students and residents. We are committed to delivering comprehensive and family-centered care with compassion and excellence. In 2016 and 2017 RCH was selected by the Portland Business Journal as one of the most admired employers in Oregon. RCH is part of Legacy Health recently selected by Forbes Magazine as one of the top 50 medium sized organizations to work for in the United States. We are a not for profit 501 (c) 3 organization for federal loan forgiveness. Portland is a city that continually ranks in the top five for livability and includes both urban and family-friendly communities. Approximately 17,000 workers bike to work year-around on 350 miles of bikeways making Portland the number one city in the U.S. for biking. Portland has a wide array of nationally recognized parks for hiking and off-road biking. Portland is a sophisticated city offering diverse cultural activities including a wide range of theater, musicals and museums open throughout the year. In the spring and summer months, Portlanders gather on the waterfront for concerts and fun activities if your desire is to step out of the city, take a hike in the spectacular Columbia River Gorge, hit the slopes of Mt. Hood or catch a wave off the Oregon Coast – all a short drive from Portland. Applications are required and can be accessed through our website www.legacyhealth.org. Please apply for position 18-0629. You will be able to insert your CV as you apply. If you have questions, please feel free to contact Vicki Owen at 503 415-5403 or vowen@lhs.org. Equal Opportunity/Veterans/Disabilities

Job Requirements:
The ideal candidate should be a BC with 3-5 years of clinical experience working with children, adolescents and families. Previous child/adolescent psychiatric consultation liaison experience required. Completion of a Child Psychiatry fellowship is required and must be able to obtain medical staff privileges. As we consider qualified candidates, we are committed to building a culture that values diversity and is reflective of those we care for.

Company: Randall Children's Hospital
Job ID: 11061441
http://jobsources.aacap.org/jobs/11061441

FOR YOUR INFORMATION

Job Description:
Randall Children's Hospital, part of Legacy Health, is actively recruiting for a full time Child and Adolescent Psychiatrist to lead the Psychiatric Consultation Liaison Program services for medically complex patients at Randall Children's Hospital (RCH). This position is a part of our system-wide Psychiatric Consult Liaison (PCL) team and is supported by our contracted 24/7 tele-psychiatric PCL services. For decades Randall Children's Hospital has been a regional leader in providing excellent care to infants, children and teens in Portland and the Pacific Northwest and is one of Oregon's largest providers of high acuity pediatric inpatient and trauma services. Our state of the art facility has a medical staff that is made up of more than 600 physicians, including pediatric medical and surgical specialists, hospitalists and community pediatricians. The Children's Emergency Department is Oregon's busiest, with more than 27,000 visits annually and staffed with Pediatric Emergency Medicine physicians 24 x7. Pediatric Critical Care and Pediatric Hospitalist attending physicians provide coverage in-house to ensure the safest, most responsive care is delivered. Additionally, there is a child and adolescent acute inpatient psychiatric unit at the Unity Center for Behavioral Health, which is a community collaboration of four healthcare systems within the Portland metro area. Randall Children's Hospital is a teaching facility for medical students and residents. We are committed to delivering comprehensive and family-centered care with compassion and excellence. In 2016 and 2017 RCH was selected by the Portland Business Journal as one of the most admired employers in Oregon. RCH is part of Legacy Health recently selected by Forbes Magazine as one of the top 50 medium sized organizations to work for in the United States. We are a not for profit 501 (c) 3 organization for federal loan forgiveness. Portland is a city that continually ranks in the top five for livability and includes both urban and family-friendly communities. Approximately 17,000 workers bike to work year-around on 350 miles of bikeways making Portland the number one city in the U.S. for biking. Portland has a wide array of nationally recognized parks for hiking and off-road biking. Portland is a sophisticated city offering diverse cultural activities including a wide range of theater, musicals and museums open throughout the year. In the spring and summer months, Portlanders gather on the waterfront for concerts and fun activities if your desire is to step out of the city, take a hike in the spectacular Columbia River Gorge, hit the slopes of Mt. Hood or catch a wave off the Oregon Coast – all a short drive from Portland. Applications are required and can be accessed through our website www.legacyhealth.org. Please apply for position 18-0629. You will be able to insert your CV as you apply. If you have questions, please feel free to contact Vicki Owen at 503 415-5403 or vowen@lhs.org. Equal Opportunity/Veterans/Disabilities

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Company: Randall Children's Hospital
Job ID: 11061441
http://jobsources.aacap.org/jobs/11061441

RHODE ISLAND
OUTPATIENT CHILD AND ADOLESCENT PSYCHIATRIST (Riverside, RI)

Job Description:
The nation’s first child psychiatric hospital, Bradley Hospital offers a unique setting for the practice of child and adolescent psychiatry. With an institutional mission focused exclusively on the mental health and welfare of children and their families, Bradley offers the full spectrum of clinical care, including inpatient, partial hospital, outpatient, in-home, residential, and school programs for children ages 6 months to 18 years old. As the primary training site, in partnership with Hasbro Children’s Hospital, for the Child and Adolescent Fellowship, Triple Board Residency, and Child Psychology Training Programs of the Alpert Medical School of Brown University, Bradley provides a vibrant clinical, academic and research environment, encouraging professionals to achieve their career goals and contribute to advancement of pediatric mental health. Work in an academic setting as a full-time attending as part of our Outpatient Service—which includes sites at Bradley Hospital, Newport Hospital, and Gateway Healthcare (a community mental health care location). The outpatient service has a multidisciplinary team of psychologists, psychiatrists, and social workers. We offer a wide-range of outpatient psychiatric services to our patients and families including individual, family, and group therapy as well as neuropsychological testing, occupational therapy for sensory disorders, and a specialized service for children with autism and developmental disabilities. Opportunities to teach child psychiatry fellows, triple board residents, psychology post docs, as well as medical students, and other trainees. We encourage our attending child psychiatrists to utilize their psychotherapy skills in the care of their patients and families.

Job Requirements:
Qualifications include Board Eligibility or Board Certification in Child and Adolescent Psychiatry, strong clinical skills and the ability to work in an interdisciplinary team. The position provides a competitive compensation package and excellent benefits. The successful applicant for will be eligible for an academic appointment at the appropriate level in the Alpert Medical School of Brown University.

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