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October 22–27, 2018
Seattle, WA
Washington State Convention Center

Call for Papers Deadline:
February 15, 2018

New Research Poster Deadline:
June 15, 2018

Preliminary Program Available:
June 15, 2018

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Cover Photo: I was recently in Bogota, Columbia and saw these youngsters playing soccer. When I was shooting, I thought that these may make possible cover shots! - Fred Seligman, MD
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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.

AACAP NEWS

The mission of AACAP News includes:

1 Communication among AACAP members, components, and leadership.

2 Education regarding child and adolescent psychiatry.

3 Recording the history of AACAP.

4 Artistic and creative expression of AACAP members.

5 Provide information regarding upcoming AACAP events.

6 Provide a recruitment tool.

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ACUTE CARE PSYCHIATRY

Is There a Pet in Your Unit’s Future?

Kim Masters, MD, and Bhagya Reddy, MD

Case

Helen is a 15-year-old female who is hospitalized for a suicide attempt using a loaded gun and has a history of multiple episodes of self-injury resulting in cuts, cigarette burns, and self-inflicted bruises to her limbs. She admits to loneliness and anxiety. She requests that her psychiatrist allow her pet corn snake to visit. A trial of pet therapy is offered as an alternative. Helen requests both. How is it best to proceed?

Introduction

The best practices answer is ‘yes’ to pet therapy and ‘no’ to the snake visit.

The use of pets in hospitals has been widespread since the idea was introduced by Dr. Boris Levinson, who noted decreased anxiety in his patients exposed to his dog Jingles. Today, the use of pets in hospitals for the amelioration of anxiety and pain is widespread. The American Humane Society’s experience managing the large “Canines in Childhood Cancer Study,” showed that hospitals individualize their pet programs. Each state has different standards for allowing pets in hospitals. The Joint Commission has no specific pet standards, but standards governing visitation, volunteers (including pet therapists), and health (including that animals should not be in food preparation areas) apply.

Roles of Pets

Dogs are the most frequent animal visitors to hospitals and the only ones the Society for Healthcare Epidemiology in America (SHEA) Guidelines recommend. According to McCullough in treatment settings, animals participate in Animal Assisted Activities (AAA) and Animal Assisted Therapy (AAT) as described in the charts below.

Research has suggested that pets provide distraction, entertain, snuggle, provide company, ameliorate pain, and most of all make the hospital unit feel more like home.

Research has suggested that pets provide distraction, entertain, snuggle, provide company, ameliorate pain, and most of all make the hospital unit feel more like home.

Table 1

<table>
<thead>
<tr>
<th>Definition</th>
<th>Animal Assisted Activity (AAA)</th>
<th>Animal Assisted Therapy (AAT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>No specific treatment goal</td>
<td>Specific goal for each session</td>
</tr>
<tr>
<td>Activities</td>
<td>Same activity with many patients</td>
<td>Individualized activity for each patient</td>
</tr>
<tr>
<td>Charting</td>
<td>Unnecessary</td>
<td>Required</td>
</tr>
<tr>
<td>Visits</td>
<td>Spontaneous</td>
<td>Scheduled</td>
</tr>
<tr>
<td>Time Length</td>
<td>As desired, 1-hour maximum</td>
<td>Pre-determined per patient need</td>
</tr>
<tr>
<td>Example</td>
<td>Child holds pets, or shows animal how to do tricks</td>
<td>Sequencing, child feeds animal one step at a time from preparing to feeding</td>
</tr>
</tbody>
</table>

Table 2. Animal Assisted Therapy Goals

| Physical Goals               | Improving fine motor skills, balancing while standing, improve wheel chair skills |
| Mental Goals                 | Increasing verbal interactions in groups, increasing attention skills, developing recreation skills, increasing self-esteem, decreasing anxiety and loneliness |
| Educational Goals            | Improving vocabulary, improving knowledge of concepts like color and size |
| Motivational Goals           | Improving participation in groups, improving interpersonal interactions, exercise |

(Table 1 and 2 Adapted^)
Certification programs provide handlers and their dogs with both AAA and AAT registration, so they can provide patients with pet treatment access. The certification process usually involves completion of health forms, questions about handler-dog interactions, the animal’s temperament, and a test/observation by a trained observer from the selected registry. Once certified, the handler-dog team join the registry and participate in healthcare visitations. In general, the dog must be able to adapt to the noisy atmosphere, ride on elevators, tolerate medical equipment, like IV poles, and be as comfortable on a patient’s bed as on the floor with a group of children.

Certification and Guidelines

There are three national therapy animal registries: Pet Partners, Alliance of Therapy Dogs, and Therapy Dogs International. The first two provide members with insurance policies against adverse events, like animal misbehavior, during handler and pet therapy sessions. The registration fees range from no cost to $30; the organizations are funded by public contributions. Certification and registration of individual handler-dog pairs is a prerequisite to membership and participation. The registries inform health facilities how to access and use their programs and provide ongoing support to members. Some of this material is in the form of YouTube videos. There is also a Therapy Manual Supporting Kids (TASK) freely available online.

Other Animal Classifications

According to the ADA National Network, a service animal is any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability including physical, sensory, psychiatric, intellectual, or other mental disability. Service animals that provide assistance to those with disabilities are covered under the federal disabilities acts. They permit an animal that is specially trained and certified to assist in mitigation of a disability; for example, guide dogs for blind individuals are permitted in all public places, including hospitals, where their owner is allowed. They can be registered with the national service animal registry. Training of rescue animals often costs up to $2,250. Often animals wear service vests.

An emotional support animal is a dog or other common domestic animal that provides therapeutic support to a disabled owner through companionship and affection. They provide emotional mitigation to people with stress or mental health issues. They are given the designation by their owners and require no training or physician certification. According to the National Support Animal Registry, validation can be obtained, if desired, online if the owner applies to a free registry. Emotional support animals are considered pets by hospitals and use is governed by those policies. Hospitals would likely allow these animals under the limits imposed on AAA animals, possibly not permitting them if the emotional support was for the visitor. Airlines, however, treat them like service animals.

Limitations

Research has found infection due to zoonoses from dogs to be similar to rates from humans. McCullough, 2016. The Center for Disease Control, American Veterinary Association, Journal of Infection Control and Hospital Epidemiology, and others have published guidelines about AAA, mostly with canines, and human-animal interactions.

Psychologically, AAA with dogs could be limited by cultural beliefs and practices and might be inappropriate for children with adverse experiences such as having been bitten or injured by an animal. In addition, while some children with abuse histories seem to benefit from these interactions, others could injure the animals. The literature suggests that injuring animals has a peak frequency in young children but is likely to become persistent in those teenagers who were physically abused with an onset in childhood. This catch-22 can be avoided by supervision of patient-animal contacts, preferably by trained handlers.

AACAP Members with Hospital Pet Program Experience

At Solnit Children’s Center, an adolescent treatment facility with inpatient and residential treatment units, AAA therapy is used to provide support and comfort. The pet therapy program is part of the rehabilitation department at the facility. A group of 6-8 dogs are brought in by their owners and spend about an hour with a select group of patients. The owners are volunteers with dogs that are raised to provide emotional support without specific training or certification. Most of the patients have posttraumatic stress disorder, reactive attachment disorder, trouble regulating their affect, or other psychiatric disorders with intense love for animals and request to have pet therapy as part of their treatment. The adolescents report pet therapy as a positive experience and look forward to spending time with the dogs each session.

Here are some experiences shared by teenagers involved in pet therapy at our program. Maya is a 15-year-old female with an extensive history of abuse and neglect. She has been involved in pet therapy for four weeks and says she is better able to cope with her anxiety and conflicts with peers and staff at the hospital after playing with the dog, as it calms her down. She recalls that she misses her pet dog while in the hospital and is able to make up for it during pet therapy session. Another adolescent female says that she cannot contain her excitement when pet therapy is scheduled as it relaxes her and decreases her feelings of loneliness. She goes on to say that she forgets her problems when playing with the animal. She finds the dog very affectionate and loves to cuddle with it. She hopes to have a dog of...
her own after leaving the hospital. The positive stories of pet therapy experience go on and on. Staff members who run this program note that the dogs have an immensely calming effect on the children, and the hour goes by too fast. They report definite improvement in positive affective states and decrease in negative affect such as anxiety and anger.

Boris Lorberg, MD, indicated that pet therapy is used at the University of Massachusetts Medical Center under a protocol supervised by Laura Curtis at the Worcester Recovery Center and Hospital, Worcester, Massachusetts.

Conclusion

There are many ways that a pet can assist a child or adolescent during a hospital stay: in an activity, in therapy, or as an emotional support or service animal, each with its own opportunities and requirements. It would be worth considering if there is a place for pet therapy in your practice.

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Resources and Accrediting Animal Agencies

Service animals
Support animals
www.nsarco.com/emotional-support-animal.html
Certification and Registration Agencies Pet Partners
petpartners.org/volunteer/our-therapy-animal-program
Alliance of Therapy Dogs
www.therapydogs.com
Therapy Dogs International
tdi-dog.org/Default.aspx

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Addressing Emotion Regulation: A Bridge Between Psychodynamic/Psychoanalytic Approaches and Contemporary Child and Adolescent Psychiatry

Introduction

In the February 2016 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*, a review highlighted the importance of the National Institute of Mental Health (NIMH) Research Domain Criteria (RDoC) project for Clinical Research for contemporary child and adolescent psychiatry. The NIMH RDoC initiative promotes research around dimensional models of observable behavior with demonstrable neural correlates. The authors of the 2016 review noted that this research initiative “will take years, perhaps decades” to provide an impact upon clinical care in child and adolescent psychiatry.

Yet, clinically-oriented research within the neuroscience construct of Emotion Regulation can have a direct impact today. Emotion regulation is defined as the ability of the individual to modify the intensity of emotional processes. It has parallels with the executive functions. These processes can be delineated into two sub-processes with defined neural correlates termed explicit and implicit emotion regulation. Explicit emotion regulation describes self-regulative strategies that are initiated and undertaken with effort, such as emotional suppression or emotional reappraisal. These processes have neural correlates in the dorsal areas of the prefrontal cortex, including the dorsal anterior cingulate cortex (dACC) and the dorsolateral PFC (dPFC). In contrast, implicit emotion regulation constitutes processes that are effortlessly employed without the individual’s awareness to attenuate emotionality; they have neural correlates in ventral regions of the prefrontal cortex, including the orbitofrontal cortex (OFC), ventromedial PFC (vmPFC), and ventral anterior cingulate cortex (vACC).

DBT: Utilization of explicit emotion regulation techniques

Marsha Linehan’s Dialectical Behavioral Therapy (DBT) includes emotion regulation as one of its four core modules. This evidence-based psychotherapy has had wide influence in both adult and childhood models of psychopathology. In a recent issue of the *Journal*, Perepletchikova and colleagues demonstrated how a modified version of this therapy could be applied to youth with the DSM-5 diagnosis of disruptive mood regulation disorder (DMDD) through several interventions including a focus on the development of emotion regulation capacities.

Implicit Emotion Regulation and Defense Mechanisms

Just as explicit emotion regulation organizes what we mean by emotion regulation skills training in DBT, there is a very important clinical application with the other half of emotion regulation, termed implicit emotion regulation. Implicit emotion regulation can organize contemporary applications of the psychoanalytic construct of defense mechanisms. Defense mechanisms were initially proposed by Freud, expanded by Anna Freud, and brought to contemporary empirical use by authors such as George Vaillant and Phebe Cramer. Addressing a child’s defenses, especially against unpleasant emotions, is a mainstay of many versions of contemporary child psychoanalytic and psychodynamic approaches. Implicit emotion regulation is a path to increased contemporary relevance for child psychoanalysis and child psychodynamic psychotherapy through RDoC-compatible studies.

Regulation Focused Psychotherapy for Children (RFP-C)

Addressing a child’s defenses can be operationalized into a manualized therapeutic approach. The systematic interpretation of a child’s defenses can be addressed, in a developmentally appropriate manner, to the child’s actions, play, and/or words. These interpretations impact the implicit emotion regulation system. This technique may yield comparable benefits to emotion regulation capacities as a whole, as do youth therapeutic interventions designed to act upon the explicit emotion regulation system, such as the applied version of DBT used by Perepletchikova and colleagues in their approach to DMDD.

Regulation Focused Psychotherapy for Children (RFP-C) packages such an approach into a short-term manualized play therapy where a child’s defenses are addressed. In the RDoC domains, a key feature in children with externalizing behaviors involves an inability to regulate their affective responses to negative stimuli. In RFP-C, there is a consistent focus on situations in the sessions that are experienced as potentially painful by the child, such as discussion of a painful subject such as parental discord or school problem. By addressing the child’s avoidance of such topics in the session, the clinician helps the child increase his tolerance of painful emotions, thus promoting the development of greater emotion regulation.

For school-aged children with externalizing behaviors, this approach offers a theoretical benefit over applied versions of DBT for children. Whereas DBT...
originated in studies with adults through explicit emotion regulation. RFP-C was developed to work with children through implicit emotion regulation. Regional differentials in synaptogenesis, myelination, and pruning create earlier maturity in ventral as opposed to dorsal areas of the prefrontal cortex. This leaves children without the maturation of neural substrates on which to intervene until adolescence and early adulthood when they develop these substrates allowing for explicit cognitive emotional controls. Children have developmental limitations in their capabilities to sit through didactic and other skills-training interventions; promotion of optimal development in the implicit emotion regulation (ER) system thus may be extremely important in children. Even in adults, empirical studies point to the potential increased importance of addressing implicit emotion regulation in various disorders.

Our pilot data demonstrates that this intervention, in addition to decreasing the categorical symptom severity of children with oppositional defiant disorder (ODD), additionally increases their emotion regulation capacities as evidenced by improvements on structured clinical rating scales of emotion regulation.

Our model permits future studies to evaluate for changes to the underlying implicit emotion regulation neural correlates in treatment responders, akin to successful research among some cognitive behavioral approaches for children with externalizing behaviors.

Conclusion

The RDoC approach is already clinically relevant as well as relevant to research in child psychiatry. Models of psychotherapy which fit into this framework, rather than those that are adapted to it, may be maximally poised to benefit from the increasing direction which neuroscience-informed clinical research may take it. RFP-C is a psychotherapy that is inherently informed by child psychoanalytic and psychodynamic principles, neuroscience, as well as developmental principles.

References


22. Etkin, A. et al. (2010) Failure of anterior cingulate activation and connectivity with the amygdala during implicit regulation of emotional processing continued on page 68
AACAP Psychodynamic Faculty Training and Mentorship Initiative

As child and adolescent psychiatry (CAP) training programs were founded in the post-World War II era, psychodynamic and psychoanalytic discoveries in relationships, in development, and in mind shaped our discipline’s ways of understanding youth and their mental disturbances. Psychotherapies, and in particular psychodynamic psychotherapy, were essential skills to be taught in CAP training programs. Our specialty has broadened with more knowledge of how the brain creates the mind and with new therapeutic avenues such as psychopharmacology, cognitive behavioral psychotherapies, and family treatments.

Importantly, both the Academy and the Accreditation Council of Graduate Medical Education (ACGME) recognize psychodynamic understanding and therapies as core skills to be taught to trainees. As such, the ACGME includes psychodynamic psychotherapy as one of the “core” psychotherapies required in training and for assessment of these skills in the training milestones. In recent years, CAP training programs have struggled to meet this educational requirement. These difficulties have many origins, off course (e.g., eroding insurance reimbursements, clinician shortages, market-model healthcare, focus on rapid-outcome, the influence of the pharmaceutical industry). Child and adolescent psychiatrists and the programs that train them regularly navigate these external forces. All too often we are left to manage complex clinical care of children and adolescents with ever-briefer visits and ever-full prescription pads.

Today, our trainees are often left in an educational lurch. Psychodynamic psychotherapy, historically a core skill of our discipline, is too frequently ceded to non-psychiatrists to teach (if taught capably at all). Regardless of one’s practice of, or relationship to, psychodynamic psychotherapy, the absence of its instruction by child and adolescent psychiatrists in CAP training programs imperils the scope of practice of our profession.

This concern for retaining psychodynamics in child and adolescent psychiatry and the desire to address the deficits in psychodynamic psychotherapy training motivated the Psychotherapy Committee to develop the Child Psychodynamic Psychotherapy Toolkit (www.aacap.org/AACAP/Member_Resources/How-to-use-the-Psychodynamic-Play-Therapy-Train-the-Trainer-Tool.aspx). Now the Psychotherapy Committee with financial support from the Samuel and Lucille B. Ritvo Charitable Fund is proud to offer AACAP’s first ever Psychodynamic Faculty Training and Mentorship Initiative (PFTMI)!

Samuel Ritvo, MD, was the first director of training in child psychiatry at Yale, a training and supervising analyst at both the New York Psychoanalytic Institute and the Western New England Institute of Psychoanalysis, and a founding member of AACAP. The Ritvos devoted their lives to the teaching of psychodynamics at Yale. Fittingly, a portion of the endowment left after their passing has been directed toward this pilot program.

The goals of the Initiative are twofold. First, the PFTMI seeks to support the development of psychotherapy training infrastructure in CAP training programs. This would be achieved by creating a mentorship program for CAP faculty to enhance the training in psychodynamic psychotherapy in their home programs by focusing with a mentor on a project tailored to the needs of their training programs. The second goal is to create a larger community of knowledgeable and effective teachers who will become the future leaders in psychodynamic psychotherapy specialty in child and adolescent psychiatry and serve as a resource for all AACAP members.

The PFTMI accomplishes this by selecting up to six AACAP members who hold faculty appointments and pairing them each with a senior mentor for one year. The pair focuses on an individualized mentorship plan and project organized during a day-long gathering preceding AACAP’s 65th Annual Meeting in Seattle. During the ensuing year, mentors and mentees are in regular contact. Projects may take on any of the many aspects of CAP training required to develop successful training programs such as didactics, case finding, or supervision. The Initiative is currently funded for two years as a pilot program. The steering committee has four members: Martin Drell, MD, Rachel Ritvo, MD, and Cecil Webster, MD, representing the Psychotherapy Committee, with A. Lee Lewis, MD, as liaison from the Training and Education Committee.

As child and adolescent psychiatrists, we have enjoyed a rich history of psychodynamic discovery, treatment, and education. As our health care landscape and its delivery systems rapidly transform, our scope of practice is at risk. It is vitally important to engage our traditional competencies alongside our new skills. The PFTMI is one measure that promises to further grow the fruit our forebearers have sown in the heart of our profession.

Applications are open now through May 1, 2018. Candidates must have an MD, DO, or equivalent degree; teach in a child psychiatry, triple board, or post-pediatric portal training program; be affiliated with an ACGME accredited training program; and be an AACAP member or have a membership application pending at the time of submission. Questions may be directed to training@aacap.org. Apply online at www.aacap.org/PFTMI.

Dr. Webster is a child and adolescent psychiatrist in private practice in Boston, a lecturer in psychiatry at McLean Hospital and Harvard Medical School, and Clinical Program Director for Diversity Health Outreach Programs at the Massachusetts Institute of Technology. Dr. Webster is a former Fellow of the American Psychoanalytic Association and recently completed a child psychoanalytic psychotherapy fellowship at the Boston Psychoanalytic Society & Institute where he is now a candidate in adult and child psychoanalysis. Dr. Webster is a member of AACAP’s Child Psychotherapy Committee. He may be reached at mail@cecilwebstermd.com.
An Innovative Model for Behavioral Health Urgent Care

The number of youth seen in emergency departments (ED) for behavioral health concerns is on the rise. Studies through the Pediatric Emergency Care Applied Research Network report that children with psychiatric-related visits require extensive emergency department resources and have higher admission and transfer rates than non-psychiatric visits. Large organizations and systems have publically made a call for better interventions to reduce the emergency room burden. Emergency departments are desperately trying to manage these mental health cases, and many do not have the staffing, expertise, or resources to support the patients and families who come in for help.

Our pediatric colleagues report a lack of training and a lack of confidence as two barriers in assessing and treating youth with mental health complaints. Many sites lack sufficient child and adolescent psychiatric expertise either in the ED or consult via phone. Telepsychiatry services are expanding to better meet the behavioral health needs of patients, especially those in areas where ED psychiatry is limited. Beyond assessment, there is another barrier in transferring a youth to psychiatric hospitals. Inpatient beds are numbered, leading to overcrowded spaces and lengthy ED stays without therapeutic intervention at the time it is needed the most. While some of these ED visits are true mental health crises such as suicidal ideation and homicidal ideation or severe functional impairment, some are non-emergency cases; however, without the mental health expertise and knowledge about most appropriate treatment plans, many youth stay in and return to the ED which may become a maladaptive pattern to cope with stress. Unfortunately, emergency departments have become substitutes for ongoing mental health care due to limited community-based mental health services and complex and fragmented systems of care.

The problem is evident, but how do we strategize for change? Many organizations and systems have set up plans and proposals, reacting to the everyday crises that present. If we all share ideas and experimental programs, we will collectively move closer to a better system. Creative brainstorming, partnership building, policy changing, and talking to colleagues will generate possible solutions.

In San Diego, a specialized urgent care clinic was designed to meet the growing needs for mental health services for youth. Price Philanthropies Foundation generously awarded Rady Children’s Hospital start-up funding for a pediatric Behavioral Health Urgent Care. The Behavioral Health Urgent Care is located in a lower income community in San Diego with a large population of refugees and immigrants. The Behavioral Health Urgent Care program includes the University of California, San Diego, child and adolescent psychiatrist, psychologist, social worker, and receptionist who also works on case management. The clinic is open from 9:00 am-8:00 pm and has walk-in services from 4:00 pm-8:00 pm, making it easier for youth and families to present after school and work. The referrals can be from other health care providers, schools, community agencies, and local hospitals. Youth from ages 5-17 are eligible for services; there is no restriction on health insurance coverage or citizenship.

Instead of waiting weeks or months for a behavioral health assessment and/or feeling overwhelmed in navigating a complicated mental health system, families have easy access to an expert team capable of completing evaluations and initial treatment plans. The team can also break down system barriers and provide case management. Patients are bridged to longer term mental health services at a local clinic when indicated. If there is a true mental health emergency warranting inpatient level of care, patients are transferred from the clinic to a local hospital. Additionally, patients who are unable to get an immediate appointment in their community may receive short term therapy or medication management continued on page 68
sessions. As an inpatient psychiatrist, I have utilized the availability of the Behavioral Health Urgent Care team in bridging my patients from inpatient to outpatient when other services are not immediately available. Records are shared, and the case can be discussed easily by phone.

This novel urgent care gives patients and families an alternative to the busy and intense pediatric emergency room which is the only emergency care center in the region and only Level 1 pediatric center in San Diego County. A calming environment with staff sensitive to the unique needs of those in psychological stress may prevent further distress or decompensation. Avoiding a trip to the emergency room is not only beneficial for families but also for the emergency care system with lengthy ED stays for behavioral health patients. Mental health related visits to the emergency room averaged 169 minutes compared to 108 minutes for non-behavioral health visits according to data collected from a nationally representative sample of US emergency department visits. Families were twice as likely to have to stay in the ER for longer than 4 hours if the presenting problem was mental health in nature. 5 According to a multicenter study of 24 tertiary pediatric emergency rooms, mental health visits without transfer or psychiatric admission logged a 3.2 hour length of stay, with other visits logging 1.2 hours. 6 Another study reported an average of 12.97 hours of wait time for pediatric patients with a primary psychiatric diagnosis, largely due to lack of inpatient psychiatric beds. 7 These studies do not report on youth presenting to general emergency rooms which may be associated with longer wait times.

Since the opening of the Behavioral Health Urgent Care, many families have avoided long waits in the ER in addition to stressful and chaotic emergency atmospheres. Some families call ahead of time and schedule an appointment to come in for an assessment. As the program is still new, we do not have the data to inform us about its impact on our local service delivery. However, since its opening, the clinic has served many families and prevented unnecessary stress, wait times, and negative perceptions of mental health treatment. As AACAP’s Past President, Gregory K. Fritz, MD, wisely stated, “Children on the waiting list do not just quietly wait. Their problems get worse and they deteriorate. They often end up in the emergency room or get admitted to a child psychiatric hospital for problems that had they been treated earlier, would be less costly.” In taking these steps to improve our delivery system, we are actively advocating for a positive change to enhance patient care and our patients’ lives.

References

Dr. Shapiro is an Assistant Clinical Professor of Psychiatry at the University of California, San Diego. She works on the inpatient unit, crisis stabilization unit, and in the ER at Rady Children’s Hospital in San Diego. She serves on AACAP’s Adolescent Committee. She may be reached at dlshapiro@ucsd.edu.

Addressing Emotion Regulation continued from page 65

Dr. Rice is Unit Chief of the Child and Adolescent Inpatient Psychiatry Service of the Mount Sinai Health System. He is additionally the Association for Child Psychoanalysis’ Liaison to AACAP. He may be reached at trice83@gmail.com.
AACAP’s Legislative Conference and Assembly Meeting will take place in Washington, DC, from April 8-9, 2018. Join us for both events to advocate for children’s mental health.

**AACAP Legislative Conference**

On April 8 and 9, 2018, learn about the legislative process and public policy issues impacting child and adolescent psychiatry. AACAP’s Government Affairs team will provide you with advocacy materials to help develop and deliver the most effective message. Once again, family advocates will be invited to join AACAP members on Capitol Hill. Join us and make your voice heard as we advocate for children’s mental health.

Visit [www.aacap.org/LegislativeConference](http://www.aacap.org/LegislativeConference) for more information or contact Michael Linskey, Deputy Director of Congressional & Political Affairs, at mlimsky@aacap.org or 202.587.9667.

**AACAP Assembly Meeting**

On April 8, AACAP’s Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.

Visit [www.aacap.org/Assembly](http://www.aacap.org/Assembly) for more information or contact Megan Levy, Executive Office Manager, at mlevy@aacap.org or 202.966.1994.
CHIP: A Primer

This year, the Advocacy Committee has made a commitment to policy-based discussions. We will highlight a variety of policy issues in AACAP News, as well as in the monthly Advocacy Liaison Network conference calls, which a representative from each regional organization of AACAP is encouraged to join. With an ongoing debate focused on funding for the Children’s Health Insurance Program (CHIP), we want to ensure AACAP members are familiar with this important health program, and understand the differences and connections between CHIP and Medicaid.

CHIP, a federal and state partnership known by different names in different states, provides child-focused health insurance to approximately 9 million middle- and low-income children whose families earn too much to qualify for Medicaid, and are otherwise uninsured. The program helps to create an important safety net for families, reduces the child uninsured rate and the burden of medical debt, and increases a child’s access to appropriate medical care to support a child’s healthy development. Children eligible for CHIP can enroll any day of the year.

In 2017, the national median household income threshold for CHIP eligibility was 255% of the Federal Poverty Level (FPL), but eligibility varies by state. Children from a family with a household income of at least 200% FPL ($41,560 in 2018 for a family of three) are eligible for CHIP coverage in 19 states. Every state, except two (Idaho and North Dakota), offers health coverage to children with a household income of at least 200% FPL ($41,560 in 2018 for a family of three). In addition, some states cover pregnant women through CHIP for those earning up to at least 185% FPL.

States have the flexibility to design their CHIP program in one of three ways. States may cover children in a separate CHIP program, create a Medicaid-extension program funded by CHIP, or create a program with a combination of a Medicaid expansion program for children based on their age or income and a separate CHIP program for other children. The benefit of this is that children whose families earn too much for Medicaid can still have the healthcare benefits required by Medicaid, such as the Early and Periodic Screening, Diagnostic, and Treatment benefit. Over half of all children covered by CHIP are enrolled in a state Medicaid expansion program financed by CHIP.

Both state and federal governments fund CHIP. Under the Affordable Care Act (ACA), federal cost sharing, which once ranged from 65 to 85 percent of CHIP costs, increased by an additional 23 percent, covering up to 100 percent of CHIP costs for certain states. Federal funding is capped through a block grant formula, which limits the amount of federal funding available for all enrollees in each state. States are left to cover any remaining costs for CHIP enrollees.

Unlike Medicaid, CHIP funding must be renewed by Congress periodically. For example, the ACA extended CHIP funding an additional two years through 2015. In 2015, the Medicare and CHIP Reauthorization Act (MACRA) extended funding for CHIP through September 30, 2017. While continuation of CHIP funding by Congress beyond 2018 seems likely at the time of writing, the need for periodic Congressional action creates tremendous uncertainty for states and families relying on CHIP in times like this when Congress allows CHIP funding to lapse. The Medicaid and CHIP Payment and Access Commission (MACPAC), as well as AACAP, recommends for at least a five-year continuation of federal CHIP funding.

As child and adolescent psychiatrists, it is important to understand these important issues so that we can better advocate for our patients and best influence the healthcare system in which we serve.

Laura Willing, MD

Dr. Willing is on faculty at Children’s National Medical Center and George Washington University in Washington, DC. She completed her general psychiatry residency and child and adolescent psychiatry fellowship at the University of North Carolina in Chapel Hill before spending last year as the APA Jeanne Spurlock Congressional Fellow. Dr. Willing is a former AACAP Resident Scholar and a current member of AACAP’s Advocacy Committee. She may be reached at lmw5p@virginia.edu.
Advocating for Advocacy

I found my experience going to Capitol Hill during the last national conference to be truly awesome. I had many trepidations and concerns before I went to speak alone with the Congressional Representatives’ staff for Philadelphia’s district, but I was shocked by the ease at which I was able to speak to issues following training and by their staff’s responsiveness to my concerns as a constituent and by virtue of being a physician. I had a similar experience when speaking with the other Pennsylvania delegates with the PA Senators’ staffers on medical policy, and the expected intimidation in my mind could not have been further from reality during these meetings. I’m surprised by what my own training in public-speaking and background in political history as an undergraduate at the Pennsylvania State University provided me in addition to the preparatory lectures provided by AACAP’s Government Affairs team just prior to the start of that day. I’m already looking forward to participating in the upcoming Legislative Conference this April, and I hope you will consider attending as well.

It was through these experiences and my background that I began to conceptualize aspects of a training curriculum that would better enable psychiatrists to become more effective advocates and agents to affect policy changes. I began personally working on gathering data on advocacy training in our specialty and others, as well as looking for avenues to provide opportunities for advocacy training in graduate medical education and/or through our organization. I hope to have the results of my literature review published in the upcoming months to address the exigent need for advocacy training in child and adolescent populations, a need that has already been recognized through mandated training for psychiatric residencies by the Accreditation Council of Graduate Medical Education (ACGME).

As providers to this same population, CAP fellowships would provide an ideal forum for inclusion of advocacy training as part of their educational requirements. We will likely need long discussions, committee reviews, etc., on how best to bring competency language for advocacy training to our fellowships and residencies, so here I am advocating for advocacy to express the urgent need for this training.

A common misconception of advocacy in our specialty is limited to “patient advocacy” without inclusion of other components. I’m sure we all feel that we effectively advocate on behalf of our patients to their families, schools, and treatment strategies. However, this limited view of advocacy and its role in our profession needs redressing. A more complete understanding of advocacy includes understanding of health policy and legislative processes, improved ability to identify social determinants impacting health care and its delivery, and effective strategies to be agents of change or knowing who to contact to enact and affect changes at the local, state, and federal level.

We have required rotations and lectures in various subspecialties during residency, but none specific to advocacy. Not all psychiatrists will work in forensics or addiction, but all should be expected to work as advocates in some form. So again, I would like to formally advocate for advocacy to be incorporated into graduate medical education training for our residents and fellows.

Dr. Sagot is currently finishing his psychiatry residency at Rowan University School of Osteopathic Medicine before moving onto fellowship in Child and Adolescent Psychiatry at Drexel University College of Medicine in July. He currently serves as a member of the New Jersey Psychiatric Association Advocacy Committee, member of AACAP’s Advocacy Committee, and the Pennsylvania Advocacy Chair and Executive Council member for the RCCAP of Eastern PA/Southern NJ. He may be reached at dr.adamsagot@gmail.com.

Adam J. Sagot, DO

In a time when political climates are rapidly changing and we continue to debate reforms of the Affordable Care Act, the need for effective representation of physicians’ views on various issues grows every day.

As physicians, we are often asked about our impressions of public policy shifts in health care. Though our unique vantage point is appreciated here, we neglect the opportunity it provides in advocating effectively for the change we are so apt to comment on. The American Medical Association has described efforts in advocacy as a professional responsibility for all physicians. This need is clearly visible in patient populations with mental illness, yet we do little to train psychiatrists to meet this responsibility effectively. As a soon-to-be child and adolescent psychiatry (CAP) fellow, I find myself wondering if my fellowship will address this gap, considering the inherent need to advocate on behalf of children.

As mentioned before, child and adolescent patient populations have little ability to represent their own voice compared to adult populations. The overwhelming need to be an effective advocate for children has been recognized by members in the past, most specifically through the many efforts of AACAP’s Advocacy Committee and the various legislative sessions and conferences they have held over the years. For those of us who have participated in these events, it’s my impression that many of us would say that advocating is a skill; however, this skill can be learned quickly and effectively with training. The outcomes of these efforts have been substantial, and the experiences were impactful on a number of levels to our patients, as well as myself.

I am advocating for advocacy to express the urgent need for this training.
We are proud to announce AACAP’s first ever Psychodynamic Faculty Training and Mentorship Initiative, made possible by a generous donation by the Samuel and Lucille B. Ritvo Charitable Fund. The initiative aims to support and advance psychodynamic psychotherapy training in child and adolescent psychiatry residency programs through faculty development. Applications are open now through May 1, 2018.

Up to six awardees design psychodynamic training projects applicable to their child and adolescent psychiatry divisions. Applicants identify a problem or an area in need of improvement but are not expected to already know how to solve the problem. That will be worked out in collaboration with AACAP mentors.

The experience includes a networking event and a daylong training session during the week of AACAP’s 65th Annual Meeting, followed by the completion of a project through the subsequent year. A stipend of $350 is provided to cover travel support for attending the required events during the Annual Meeting.

**CANDIDATES MUST:**

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

To learn more about the award and application process, visit AACAP’s Awards page at [www.aacap.org/PFTMI](http://www.aacap.org/PFTMI). For questions, contact training@aacap.org.
ACADEMY & ASSOCIATION 101

What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Childhood Victims of Trauma Internationally

Syed Arshad Husain, MD

Introduction

Wars, natural disasters, community violence, and terrorism are rampant worldwide. At any given time, more than 50 armed conflicts are raging around the world; natural disasters such as earthquakes, hurricanes, tornados, tsunamis, and floods cause significant death and destruction on a regular basis. Children, elderly people, and women are the most frequent victims of these events. Moreover, recent armed conflicts have generated hordes of refugees escaping their homelands, creating economic, social, and political challenges in neighboring host countries.

Many of these refugees are children. Since 1980, the United States has hosted over three million refugees, nearly one-third of them children under 10 (Migration Policy Institute). This article reports my personal experience with, and research on, children living in war zones and disaster areas, and on my work with refugee children currently in a local school system.

Background

In 1995, in response to the mental health needs of children affected by the 1992–1995 war in Bosnia, I founded the International Center for Psychosocial Trauma (ICPT) at the University of Missouri—Columbia. During that war, the ICPT team visited Bosnia 25 times. Its capital—Sarajevo—experienced the longest siege in the world’s history of warfare. According to UNICEF, more than 30,000 shells dropped on the city daily, killing more than 6,000 children and reducing the city to ruins.

Since its founding, ICPT teams of psychiatrists and mental health professionals led by this author have traveled to war zones and disaster areas more than 80 times, providing mental health help to affected children and families. We traveled to 18 countries, including Bosnia, Kosovo, Palestine, India, Pakistan, Indonesia, Sri Lanka, Russia, Afghanistan, and Chechnya. In the United States, ICPT teams traveled to Tulsa in the aftermath of the Oklahoma bombing (1995), to New York City after 9/11 (2001), to New Orleans and Baton Rouge after Hurricane Katrina (2005), to Joplin, Missouri, after a 2011 tornado, and to Puerto Rico in 2017 after Hurricane Maria.

Impact of Traumatic Events on Children

In 1996, the ICPT studied 791 children living in besieged Sarajevo. Twenty five percent of them had been shot at by snipers and 71% had a family member who had been killed. Seventy seven percent of the children had trouble sleeping; a similar proportion reported feelings of guilt. Compared to the 9% of their peers who were not exposed to such extreme stress, an astonishing 92% reported suicidal thoughts.

Startle responses to loud noises were often observed, symptoms that continued even after the war had ended. Nightmares, flashbacks, and depression were commonly reported. Forty one percent of the children met DSM-IV criteria for posttraumatic stress disorder (PTSD). Forty percent met criteria for depression.

One 11-year-old boy would wake up in the middle of the night, screaming and running to the basement of his house to take shelter as he and his family had done during the war. We only discovered the trigger for this behavior after learning that he slept in a room with his grandfather. After midnight, the grandfather would start snoring, producing a whistling sound that reminded the boy of the whistling sounds of wartime motor shells thrown at the city from guns deployed on the surrounding mountains. These nightly terror episodes subsided after the child began sleeping in another room.

Besides the psychological symptoms, we observed stunted growth in some children. One 7-year-old girl’s hair turned gray after witnessing her father’s murder.

We found that the symptom complex resulting from being exposed to life-threatening situations was similar across countries and cultures. Recurring thoughts, avoidance, and hyper-arousal were common. In Sri Lanka, after the 2004 Indian Ocean tsunami, children would refuse to take a shower. In Bande Ace, Indonesia, also a city swiped by the Indian Ocean tsunami, children began to avoid flushing toilets as the sound of flushing water reminded them of the death and destruction the tsunami caused. Following a 2001 earthquake, the children in Gujrat, India, were reluctant to put their feet on the ground while sitting on a chair, because passing cars made the floor vibrate in a way that reminded them of the earthquake’s aftershock.

Traumatic events frequently impaired the children’s concentration and attention, affecting their academic performance. Following the 1995 Oklahoma bombing, Tulsa teachers reported that after students watched the gory TV pictures of death and destruction that the bombing caused at the Murrah Federal Building, they stopped doing their homework, had more fights during recess, and ran in the school corridors rather than walking as they had before. The children in Karachi, Pakistan, were afraid to go to school after hearing about the massacre of 150 people—mostly children—in a school in Peshawar, a city 1,000 miles north of Karachi.

Special Challenges of Refugee Children

According to a Migration Policy Institute study of Syrian children, 79% of refugee children had lost someone in their family through death, 60% had seen someone get shot or otherwise seriously hurt, and 45% were thought to have developed PTSD.
Refugee children face additional challenges in the United States. Cultural and language differences make it hard for them to integrate with peers in schools and neighborhoods. In a random survey of 105 refugee students enrolled in Columbia, Missouri, public schools, 70% had symptoms of PTSD, 60% had symptoms of attention-deficit/hyperactivity disorder (ADHD), and 50% suffered from depression. These increased rates were attributed to additional stresses that these children faced in the United States.

**Recovery from Trauma**

Generally, the acute shortage of physicians and mental health professionals around the world increases in the aftermath of disaster and war, preventing timely mental health “first aid.” To fill this gap, the ICPT developed a model of care known as Teachers as Therapists. The ICPT team has trained more than 6,000 teachers and mental health professionals worldwide. Under this model, local teachers are trained to identify symptoms of PTSD and depression and to provide group therapy, relaxation, and guided imagery techniques along with using art and play. They implement these techniques as part of the usual curriculum during a mental hygiene period. Teachers are selected because by training and proximity with children, they can tell the difference between normal and abnormal behaviors. Most children trust them, and they also have tools to calm children down. An ICPT outcomes study has demonstrated the effectiveness of teachers in identifying PTSD and depression and providing initial intervention in the classroom setting.

Resiliency is the ability of a child to bounce back from difficult experiences and hardship. It depends on endogenous attributes such as positive temperaments and higher intelligence, and environmental factors such as positive attachment, bonding, and adult support. It is generally agreed that stress reaction is a normal response to abnormal life experiences and that most children recover from the symptoms within weeks of exposure to traumatic events. In our study, 40% of Bosnian children suffered from PTSD, but 60% did not. This latter group had an initial reaction to stress but bounced back within two to three weeks because of their natural resiliency.

Although we wish these terrible events never occurred, we have also observed that the impact of traumatic experiences can sometimes be positive. Adversity can mobilize inner strengths and improve self-esteem. We remind surviving children that they are special, having survived the adversity, because instilling hope for the future is a fundamental strategy in the recovery from trauma. They can then move on and fulfill their dreams. ■

**References**


Dr. Husain is a professor emeritus of Psychiatry and Child Health at the University of Missouri-Columbia, School of Medicine where he founded International Center of Psychosocial Trauma. Since 1995, Dr. Husain and his trauma teams have travelled to 80 warzones and disaster areas in 18 different countries, and he has trained over six thousand teachers and mental health professionals in trauma psychiatry. He has authored six books including Hope for the Children: Lessons from Bosnia (2001) and Road Map to Power (2015). He has been recognized by APA, AMA, and AACAP for his work with traumatized children. He can be reached at husains@health.missouri.edu.

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Since 2010, the Life Members Fund has made an investment in 92 residents and 78 medical students. This includes 17 residents and 13 students in 2016! If you attended the Life Members dinner in NYC, you got to meet these young superstar future Owls!

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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.

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

Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.
The Children of Château de La Hille
Sebastian Steiger; Translated by Jocelyn How; Preface by Henry Massie
Lexographic Press 2017
Paperback: 372 pages – $18.95

In 2016, AACAP member, Henry Massie, MD, was asked to facilitate the publishing of The Children of Château de La Hille in the United States. Originally published in German and French in the 1990s, Sebastian Steiger’s memoir tells the story of 100 Jewish children who found refuge in a château in the foothills above the Lèze River in Southern France during World War II. The children, many of whom were orphaned, came from Germany, Austria, and Poland. With the aid of young volunteers from the Swiss Red Cross – Aid to Children (Croix Rouge Suisse – Secours aux Enfants), a dynamic and thriving community grew. Those devoted to helping the children included Sebastian Steiger, who in 1943 at the age of 25, elected to move to the château after completing his teaching certificate. His memoir, including photos, chronicles the daily life of the château, with stories of humor, mishaps, tragedy, and the remarkable resiliency of a small group of people facing unspeakable danger and adversity. Though a story from the 1940s, The Children of Château de La Hille is a story of today, reminding its readers of the millions of child refugees and orphans around the world.
We are proud to announce AACAP’s first ever Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award, made possible by a generous donation from Ms. Lisa Yang. Her donation was instrumental in developing the AACAP Marilyn B. Benoit, MD, Fund. This award seeks to provide an experiential opportunity to those interested in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention.

Mentors must have experience in key issues in any of these areas, but they themselves do not need to be child and adolescent psychiatrists by training.

For additional information, please visit: www.aacap.org/CMMA or contact us at clinical@aacap.org.
Honor Your Mentor

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

**Felicity Adams, MD**  
Submitted by Richard Ha, DO

My fellowship director, Dr. Felicity Adams, is the best mentor ever. She has opened my mind to new possibilities, challenged me to be an advocate, and has nurtured my aspirations. I chose to stay in Roanoke, Virginia, for fellowship because of her kindness and professionalism. She is the kind of person that will get to know my parents when they visit and buy our residents brunch on a Saturday morning to discuss their interest in Child Psychiatry. When people ask me what kind of doctor I want to be, I tell them that I want to be like Dr. Adams.

**Paul H. Arkema, MD**  
Submitted by Paul Dagincourt, MD

Dr. Paul Arkema has been a seminal influence in my growth and development as a Child & Adolescent Psychiatrist. Dr. Arkema graduated from University of Pennsylvania School of Medicine in 1967, completed his Adult Psychiatry residency at Mass Mental Health Center, and Child/Adolescent training at McLean Hospital. He has practiced more than 50 years. For at least 40 years, Dr. Arkema led psychiatric clinical clerkships at Boston University School of Medicine, and in 2003 received the 11th Annual Nancy C.A. Roeske, MD, Certificate of Recognition for Excellence in Medical Student Education. For the many years I have had the good fortune to be mentored by Dr. Arkema, I have learned how each patient deserves my undivided attention and understanding.

**Rick Bevins, MD**  
Submitted by Cindy Chou

Dr. Bevins is a great mentor at the University of Nebraska Lincoln’s Neuroscience program. Despite not being my primary mentor, he always offered candid and critical career development advice that has grown to become even more important than scientific knowledge at times as I advance into the next phase of my training. He is also an absolute role model, and garners respect from everyone that encounters him not only for his absolute intellectual accomplishments, but also for the generosity, respect, kindness, and nonjudgmental treatment of all. There was a period during my pre-doctoral training, when my workload became intensely overwhelming, that I approached him for tips on how to manage. He kindly gave me a mini workshop with useful tips that I use to this day to keep me disciplined and emotionally healthy.

**Sumru Bilge-Johnson, MD**  
Submitted by Rakin Hoq, MD

I first met Dr. Bilge-Johnson in medical school when I did a child psychiatry rotation. She welcomed me whole-heartedly, answering every question and concern I had with utmost sincerity. I never felt so welcomed on a rotation before. I’m now in my second year of residency, and she has since always been accessible to me for guidance, answers, assurance, and even career opportunities. I feel eternally grateful for her being my AACAP mentor because the support I receive from her is second to none. Thank you Dr. Bilge-Johnson for being such a wonderful role model and inspiration.
Robert Block, MD
Submitted by Dean Martin, MD

One of my most important mentors was not a Child Psychiatrist but a Pediatrician, my residency training director before I switched to Psychiatry, and then, Child Psychiatry. Dr. Robert “Bob” Block (who would later become President of the American Academy of Pediatrics) taught me to recognize the “psychosocial” as well as the “medical” problems of my patients—to identify signs of abuse and neglect, substance abuse, and mental health problems—and to take an active role in leading the treatment of those issues. He believed in being “the best doctor in the world” to one’s patients—meaning being fully responsive to and responsible for one’s charges—not deferring and referring what needed to be done now.

Gabrielle A. Carlson, MD
Submitted by Jaclyn Chua, DO, Tahsin Hasan, MD, and Katherine Pan, MD

We feel truly blessed to have had her nurturing presence during our training, not only as an educator but as a friend. Despite her many other responsibilities, her genuine concern for our learning and personal growth was always evident and appreciated. It is her infectious energy and limitless passion for all that encompasses child and adolescent psychiatry that we will cherish when we look back on how it all began.

Eduardo Dallal, MD
Submitted by Oscar Sánchez-Guerrero

I would like to honor Dr. Eduardo Dallal, my mentor, who studied at Chicago University, and came back to Mexico and began teaching young Psychiatrists (as me) to become child and adolescent psychiatrists. He was my clinical supervisor and psychotherapy supervisor. Mostly I learned from him how to deal with Pediatricians (their fears, their way of facing illness), and I am quite convinced that thanks to his mentoring I became a professor in the National Institute of Pediatrics in Mexico, and to develop the new medical residency in Child Psychiatry for next year.

He was very sarcastic but very interested in our extracurricular activities (art, politics, etc.). I always heard from him that psychotherapy should be a work of questioning all that a patient says, as the main tool to understand what is going into the thinking of a boy.

I am very grateful for all his mentoring, and for the academic and human support he gave me.

Dr. Cecilia DeVargas
Submitted by Peter Sangra, MD

Dr. DeVargas is our Program Director at Texas Tech El Paso, for Child Adolescent Psychiatry, and she is amazing, encouraging, positive, nurturing, and builds us (Fellows) up. She is the backbone of the Child Adolescent Psychiatry Fellowship Program! Dr. DeVargas has taught numerous Fellows/Residents over the years, and our common request is to have more time with her. Dr. DeVargas teaches us how to apply principles within textbooks to actual patients and use Second Order Thinking and to incorporate the family system to find the solution for the child. She is more than just a mentor. Most of us do not have family here in El Paso, and she looks out for our best interest, making sure we are well rested, appreciated, and respected. We feel that we are a family here in El Paso. I could have not imagined mutual interests in education and learning through AALI. Dr. Chandra’s wisdom and perspective transcended distance and encouraged creative email conversations about child psychiatry, wellness, and social good. Thank you Dr. Chandra for your inspiration and mentorship to not just me, but many others. Your contributions make this world a better place.
a better program and a better Program Director. Thank you Dr. DeVargas for being you and helping us become better future Child Adolescent Psychiatrists. There’s no better place to honor you than in the AACAP News March/April issue.

**Norbert Enzer, MD**
Submitted by Virginia Q. Anthony

I was lucky to serve as Executive Director of AACAP for 39 years. I learned so much from so many, yet Norbert Enzer was a constant in my learning. I met him before I joined AACAP, at the first meeting of the State Mental Health Directors of Children and Youth. An important look from Norb kept me sane. He always was effective in focusing on the important, executing the doable, and having a good time in his leadership.

First, he was program Chairman, going beyond the scientific and career building (which he was good at) but creatively bringing in children and childhood to the meeting. He invited the author of Goodnight Moon to speak and the Director of the San Diego Zoo to talk on parenting and mothering problems at the zoo.

Norb went on to co-chair “Project Future, A plan for the Coming Decades,” our one and only strategic plan. This was a map to embrace research and expand AACAP. Later, as Chair of the Code of Ethics Committee, he basically wrote ours, with a clarity and determination that served the specialty.

He also chaired the committee to celebrate the Academy’s 50th anniversary. This celebration encompassed many dimensions, including the taping of Norb giving a brief history of AACAP. This has been a must for all new employees of the Academy.

And what did I learn from Norb? He taught me to cherish our members and particularly the Lifers, to embrace diversity, to take things with a grain of salt, to try to take myself seriously, and to have fun.

Thank you, Norbert Enzer, dear friend, with an enormous imprint on the specialty, the Academy, the Boards, and so many of our members.

**Gordon K. Farley, MD**
Submitted by Frederick Hebert, MD

I nominate Gordon K. Farley, MD. He was born in China to missionary parents. He became an Associate Professor at University Colorado Health Sciences Center with numerous publications and recently retired to fund his grandchildren’s college expenses. He taught many courses including one we shared, psychopharmacology, for the fellows in child psychiatry. He always prepared careful extensive information for these lectures which were well-received, often better than my own. His whimsical sense of humor prevailed in all his teaching and interactions. We have overall gotten along very well, but late one morning we stood over an ancient copying machine which resisted our efforts to fix it. “It would be nice if we just could erase everything we’ve done so far,” I said, grumpy and discouraged. “Oh you can: just rub on the glass in this corner,” he said, without a smile. It took me a moment to realize he was just kidding, but then we laughed together. We still are, now in retirement, and nearly so.

**Walter J. Freeman, III, MD**
Submitted by Douglas Kramer, MD, MS

I had the great privilege of being mentored late in my career. Walter J. Freeman was the preeminent neuroscientist of the 20th century. He presented his research at three AACAP Biological Roots of Psychiatry Symposia (2003, 2006, 2012). He knew the only way I would truly learn the science was to have me write his abstracts. In a very real way we were friends and colleagues, but we both knew I was the student. He called me nine days before he died in 2016. We both knew he was calling to say goodbye, although neither one of us said the words. His last to me were, “I love you,” as mine were to him. I hope someday to be half the mentor he was to me.
Amy Funkenstein, MD, Sylvia Krinsky, MD, and Neha Sharma, MD
Submitted by Kara Curry, DO

I thrive on positive encouragement. Who does not? I especially thrive on it when it comes from those whose skill and expertise I deeply admire. “You were born to be a child psychiatrist!” “Keep up the hard work” “You have great instincts” are examples of encouragement my inspiring mentors—Drs. Amy Funkenstein, Sylvia Krinsky, and Neha Sharma—have warmly and graciously provided in times I’ve felt uncertain of myself in this profession, whether they sensed that at the time or not. Although they provide much more than this, this brief example hopefully illustrates a way in which their mentorships are supportive, motivating, and uplifting.

Daniel Gih, MD
Submitted by Jessica Thai

Dr. Daniel Gih was my mentor for my research project and always made it so I could easily reach him (even at times responding back at midnight) no matter how trivial they seemed. He made countless revisions to my posters and manuscripts and guided me through my first AACAP conference, allowing me to tag along on his networking and business dinners and even went on a manhunt alongside me to try to find a director at the conference I was hoping to meet. It is because of mentors like Dr. Gih that students are passionate about entering the psychiatric field.

Gregory L. Hanna, MD
Submitted by Christina LaRosa, MD

Dr. Hanna has been a mentor to me since I was a freshman undergraduate at the University of Michigan. He not only took me on as a research assistant but also met with me regularly to discuss the nature of his work. I developed a fascination in the field, and almost ten years later, I am back at U of M as a child fellow continuing the same research with him again as my mentor. I am grateful to have had the opportunity to learn from him and thank him for inspiring my interest in the field of child psychiatry!

Sarah E. Herbert, MD, MSW, Gail A. Mattox, MD, Courtney L. McMickens, MD, MPH, Phillip Murray, MD, Juliet Muzere, MD, and Sarah Y. Vinson, MD
Submitted by Kevin Simon, MD

Throughout residency at Morehouse School of Medicine, I have had an outstanding team of Child & Adolescent Psychiatry (CAP) mentors, starting with department chair Dr. Gail A. Mattox and faculty members Drs. Sarah E. Herbert and Sarah Y. Vinson; through APA/AACAP fellowships Drs. Courtney L. McMickens, Phillip Murray, and Juliet Muzere have served as mentors. My mentoring experience is one of the reasons I plan to pursue CAP training. Through mentorship, I was able to create and present a workshop “Empowering Trainees and Guiding Careers: Mentors and Sponsors in Clinical and Organized Child & Adolescent Psychiatry” at the 2017 AACAP Annual Meeting.
Honor Your Mentor

Leslie Hulvershorn, MD
Submitted by Samantha Parkhurst

Dr. Hulvershorn introduced me to research in child psychiatry. Through her, I was able to learn a great deal about antipsychotic medications as well as other psychotropic medications. Through her, I was able to get my first publication in a journal. I also got the opportunity to participate in multiple clinical meetings learning both about patient-specific conditions but also addiction and substance abuse. With her, I had a great summer and learned so many different things about child psychiatry but also research that has helped me further in my career.

Sansea Jacobson, MD
Submitted by Sarah H. Arshad, MD

Dr. Jacobson is the program director trainees dream about – in addition to her intelligence and academic productivity, she provides incredible personal and professional mentorship and genuinely cares about the wellbeing as well as the professional development of everyone in her program. She has connected me with other professional mentors, helped me think about my own scholarship, offered my parents her home when they visited after I became unexpectedly sick, reviewed my CV, given me personal life advice, and on a daily to weekly basis continues to ask how I am doing. If I could, I would be her trainee forever.

Heather Jones, MD
Submitted by Lucy Chisler

Throughout my first year of medical school, we have been asked to reflect upon what makes a great physician and to think about the role models we have – for me, Dr. Jones immediately comes to mind every time. Dr. Jones was supportive of me on my path to medical school, and her encouragement helped me get through the stressful application process. Dr. Jones brought a great sense of humor to our child and adolescent psychiatry unit, and I hope to one day be a positive and encouraging presence on the unit for patients, families, and co-workers, just like Dr. Jones.

Clarice Kestenbaum, MD
Submitted by Carol Kessler, MD

I connected with Clarice Kestenbaum as my supervisor in the child psychotherapy institute that she founded with Paulina Kernberg. She became my mentor as she connected me to the world of AACAP, introducing me to the Juvenile Justice Task Force. She encouraged me to take up the invitation to co-edit a book for Cambridge University Press devoted to this topic. She has supported my calling to work in the margins – in the Bronx, with undocumented immigrants, in Central America and to present my work in national meetings. She has become a true colleague, friend, and mentor.

Naomi Leslie, MD
Submitted by Kateland Branch Napier, MD

In my 3rd year of residency, Dr. Leslie agreed to be my therapy supervisor (I did not know at the time that supervising residents in the general adult program was not really part of her job description). I learned more about adult and child psychotherapy during that time than I had prior, but more importantly for me at that time in training, I found a mentor. She was a constant source of support and encouragement during my time there and since. Her office was a safe place to go for guidance about residency, fellowship, careers, and life in general. Thank you!

David A. Lewis, MD
Submitted by Gil Hofman, MD, PhD

“Being a role model is the most powerful form of educating... too often fathers neglect it because they get so caught up in making a living they forget to make a life.” ~John Wooden

David Lewis creates an environment that inspires life and growth, rather than one that is caught up in making a living. He is an exemplary role model, not only during momentary successes and setbacks, but also during our
daily pursuit of excellence. Thank you, Dave, for being an endless source of fuel that stokes my passion to be a physician-scientist role model.

Annie Li, MD, Cynthia Pfeffer, MD, Susan Samuels, MD, Jessica Simberlund, MD, and Xiaoyi Sherry Yao, MD
Submitted by Emily Menand

I would like to honor my mentors at Weill-Cornell: Dr. Annie Li, Dr. Xiaoyi Sherry Yao, Dr. Jessica Simberlund, Dr. Cynthia Pfeffer, and especially Dr. Susan Samuels, who helped make possible my attendance at last year’s conference and who has been a guiding force since my very first week in medical school. Dr. Li shaped my path by providing feedback on my first psychiatry patient note, Dr. Yao by observing my first mental status exam, and Dr. Pfeffer by recognizing my passion and introducing me to AACAP. It has been a privilege learning from these outstanding teachers and exceptional psychiatrists.

Dr. Ming Li
Submitted by Cindy Chou

Dr. Li at the University of Nebraska Lincoln’s Neuroscience program is a mentor that I will forever be grateful for in many ways. During my initial search for a research mentor, when I struggled to find someone that has the combination of mentorship style and research content I sought, he openly gave me an opportunity. His trust in me gave me the confidence and discipline to pursue the research previously unfamiliar to his group, and he provided me the additional mentorship connections through his network that helped me succeed in establishing the projects I envisioned. As a training development mentor, he was a role model for his tireless work ethic, humility despite success, genuine love for knowledge, and curiosity to develop research questions. Even now as I moved on from his group, he reminds me to continue to work on projects and not become complacent. I know he will be an important figure in my development for life.

Howard Liu, MD
Submitted by Cindy Chou

Dr. Liu has been a great mentor since my first year as a medical student at the University of Nebraska Medical Center. He has kept me focused on my goals and always offered practical and honest feedback without sugar coating, yet always with respect and kindness. At the most recent AACAP meeting, he made sure we had time to meet and catch up, and continued to be supportive and was genuinely happy for my progress. He truly cares about fostering young trainees and I know will continue to be a great influence in my development.

Jocelyn Lluberes, MD
Submitted by Cesar Lluberes, MD

I would like to nominate my sister Dr. Jocelyn Lluberes, Medical Director of the Philadelphia region’s new and only child crisis response center (CRC), for recognition of her outstanding work in helping develop and open this new CRC. She is the reason I have chosen to pursue a career in CAP, and her dedication to the wellbeing of children and their families has further inspired me. The city has been in crisis for the past several months given that there was no CRC while my
sister and staff at Belmont worked diligently at getting the new center up and running. They opened for service on January 4, and I feel strongly that their efforts should be recognized by the medical community.

Mirela Loftus, MD, PhD, Salma Malik, MD, MS, and Lisa Namerow, MD
Submitted by Sophia A. Walker

I wish to honor my mentors at the Institute of Living/ Hartford Healthcare in Hartford, Connecticut, where, as a recipient of AACAP’s Summer Medical Student Fellowship Award, I gained invaluable research and clinical experience. Thank you to my primary mentors, Salma Malik, MD, MS, (now at Sidra Medical Center in Doha, Qatar) for your support and insight throughout the design and implementation of my project, Lisa Namerow, MD, for challenging me to stretch my creativity and refine my problem solving skills in clinical research, and Mirela Loftus, MD, PhD, for teaching me invaluable patient interview and management skills. Your teaching is a quintessential illustration of the dedication to mentorship that is evident in this field. This singular opportunity to be your student has made me so excited for a bright and interesting future in child and adolescent psychiatry!

Patrice Malone, MD, and Sarah Vinson, MD
Submitted by Francois Williams

I’d like to thank both Dr. Sarah Vinson (Morehouse School of Medicine) and Dr. Patrice Malone (Columbia University College of P&S) for guiding me professionally and personally through my medical education at Morehouse School of Medicine. Thank you for all the support that you have shown me, particularly this past summer as both of you afforded me a more in-depth look at the wide variety of subspecialties in psychiatry, that will supplement the exposure I receive next year during my clinical clerkship as a medical student. I want to express my deepest gratitude for affirming my nascent interest in psychiatry and for setting such a great example.

Peter Metz, MD
Submitted by Kristin Bevington

My mentor at UMass Medical School, Dr. Peter Metz, has been an invaluable source of support, encouragement, and inspiration. Through him, I was introduced to AACAP and had the privilege of attending my first national conference. Clinically, he is a joy to work with, and I have learned a tremendous amount from him, especially regarding play therapy and the mental status exam of young children. It has been truly an honor to learn from such a gifted child psychiatrist and dedicated teacher.

Ayesha I. Mian, MD
Submitted by Dr. Huma Baqir

I first met Dr. Mian in 2014. As my interactions with her grew in multiple capacities, I began opening up to her and approaching her for both professional and personal guidance. Dr. Mian, compassionate and far-sighted as she is, not only made time for me and my thoughts, but also invented platforms for me that took my professional experience to another level...and I can never forget that. She continues to invest in me—as the clinician, leader, and the woman that she is—so I can be the best version of myself. I would be lost without her.

Salvador Minuchin, MD
Submitted by Lee Combrinck-Graham, MD

My Mentor, Salvador Minuchin, MD, was a Psychoanalyst certified by the William Alanson White Psychoanalytic Association, who expanded Harry Stack Sullivan’s thinking about people in con-text to probably the most practical, straightforward, compassionate, and effective way of treating children and adolescents - in their families. His approaches to families and children came to be known as “Structural Family Therapy,” but those of us who remained close to him over the decades knew that his approaches were ever evolving, incorporating
new ideas and vocabularies as these came into professional conversation. This view of children in families and in schools and in larger systems was always based on the practical – “What do you see? What do you want to be different? Make it happen?” These notions are the voices of Minuchin that I continue to hear as I practice, now, 43 years after finishing my Fellowship at the Philadelphia Child Guidance Clinic and while fighting through what seems to me to be a disease-oriented and medication obsessed child “mental health” system.

He was awarded the Blanche Ittleson Award for Research in Child and Adolescent Psychiatry, in 1981 for his research on families of children with psychosomatic conditions, specifically diabetes, asthma, and anorexia nervosa, but he did not continue to associate himself with Academy be-cause it was too much of a guild for him. Similarly, he ceded his position as Director of the Division of Child Psychiatry at the University of PA, because he did not want to be involved in university politics. He once fought the team to Accredite the Child Psychiatry Training Program (Adolescent had not been added at that time) declaring that he did not need someone else telling him what is child psychiatry and what he should teach, you yielded to the inevitable by turning this process over to the Division Director and Training Director. While in Philadelphia he led the above mentioned research (in close collaboration with pediatric staff from the Children’s Hospital of Philadelphia), but also continued a focus on working with poor families and racially and ethnically diverse families, developing, with Jay Haley and Braulio Montalvo, a very successful training program for indigenous therapists. And after retiring from the Philadelphia Child Guidance Clinic and leaving Philadelphia, with his wife, Patricia Minuchin, a developmental psychologist, he went to work on the Child Welfare System in NYC, and she developed a model for foster families fostering not only children but their mothers.

There are people with whom you study, and you carry their teachings with you. Minuchin was one of those for me, but the teachings evolved, and I had to keep listening, even during the later years of his life, when I did not see him, but could hear him. He died at 96 on November 29, 2017.

Howard Moss, MD

Submitted by Evan Trager, MD

Dr. Howard Moss was my mentor throughout my adult psychiatry training, helping me apply, receive, and complete the NIDA-AACAP Resident Training Award in Substance Use Disorders. One quality that I really appreciated is that he would almost never tell me the answer to the question I asked; instead he would lead me, either Socratically or bibliographically, to a point where I felt comfortable positing my own answer. I believe his guidance and unwavering support was instrumental in my securing the child psychiatry fellowship of my dreams, and I’ll be forever grateful.

John Neumaier, MD

Submitted by Cindy Chou

Dr. Neumaier is one of the most supportive mentors I have ever encountered. Even as a naive undergraduate student at the University of Washington, he always ensured he provided ample support and individual attention to each of his trainees. No matter my success or failures, he treats me with respect and speaks without judgement. During my residency match process, despite having other serious personal concerns to attend to, he selflessly gave his valuable time up to listen and provide me feedback that helped shape my ultimate decisions.

Roberto Ortiz-Aguagyo, MD

Submitted by Nasuh Malas MD, MPH

I would like to share my appreciation and support to a dear friend and wonderful mentor, Dr. Roberto Ortiz-Aguagyo. Roberto has been a close mentor and a staunch advocate of my academic and clinical development from early training as a Triple Boader to early faculty. He has been a voice of support and guidance as I developed a child and adolescent consultation-liaison service and has provide much wisdom and thoughtful words over the years. For him, I am greatly blessed and cannot thank him enough for all the mentorship he has given me over the years!
HONOR YOUR MENTOR

Deepak Prabhakar, MD, MPH
Submitted by Shehryar Khan, MD

Dr. Prabhakar has been very instrumental in fostering, harnessing, and supporting me in my career growth. He has helped me develop the mindset of striving to continue to learn to become a better clinician and a better human being every day. He has also been my personal wellness ambassador, and I have positively embraced several aspects of wellness in my personal life because of his help.

Timothy Rice, MD
Submitted by Mitchell Arnovitz

My name is Mitchell Arnovitz, and I am a second-year medical student at SUNY Upstate Medical University. I received AACAP’s Summer Medical Student Fellowship in Child and Adolescent Psychiatry to pursue research over the summer with Dr. Timothy Rice, chief of inpatient child and adolescent psychiatry at the Icahn School of Medicine. The mentorship that I received from Dr. Rice was, and continues to be, instrumental in my journey to becoming a physician. His dedication to my personal and professional development, as well as his continued support and guidance, has had a major impact on my life.

Robert F. Rohner, MD (“R2”)
Submitted by John T. McCarthy, MD

“Jesus, Johnny, I thought you’d never get here!”

That’s how I first met my Mentor, R2, entering his office at Upstate Medical School for my admission interview. Smiling broadly, a gleam in his eye, with bushy eyebrows used effectively for emphasis, R2’s impact on my medical career had just begun.

His mentorship continued throughout my four years, culminating in taking his elective in Pathology. Having absolutely no intention of becoming a pathologist, rather, I wanted to absorb what made R2 a great person, physician, and mensch. He did not disappoint. R2 taught me three “golden rules” that made all the difference: take time for yourself and your family, be passionate about all you do in life, and finally, unless you’re on call, NEVER answer the phone.

John Sargent, MD
Submitted by Eric Goepfert, MD

I first met Dr. John Sargent as a medical student, when I was the only student, along with a child fellow, on his service. It was a county hospital, which provided medical care to uninsured adults and undocumented children. Thus, the children on our general med-surg unit had almost unanimously been through a lot of difficulty in their short lives. Dr. Sargent was a pediatrician and psychiatrist, and he (thus, I) attended morning rounds with the pediatrics residents. As a consulting psychiatrist, he met with every child on the service. As the psychiatry consult medical student, I got to meet with these children and their families, often without the child fellow having seen them, and Dr. Sargent would provide direct supervision to me, on these cases, meeting with them to make interventions and clarify assessment questions. It was through this work that I decided to become a psychiatrist, as opposed to another type of physician. The reasons were the comprehensive way that his work required he think about the patients, the concerted effort at understanding both the patients themselves but also their families, and the apparent healthy and balanced attitude Dr. Sargent had about his work. Unlike many of the attending physicians that I had met and worked with, he balanced an immense knowledge base with a refreshing practicality; he had
many ideas of things to do with family members, therapeutically, rather than simply using family interviews to gather information; and he not only shared his awareness and familiarity of literary and artistic versions of life and living, but he showed me, by example, how these things that are presented in art carry wisdom for how to do psychotherapy and how to understand people. He was an excellent example of how to be, and my sense of him led me to think that psychiatry was the best option for me, in its welcome and beneficial invitation for ideas from realms out-side of medicine, and the way that such ideas helped one know better families and individuals. I went off to do residency and moved across the country. I progressed through training, unsure of what I would do next, trying to follow my intuition, based on my experiences. Well, the seed, I suppose, had been planted. Ultimately, I went to a child/adolescent fellowship and had some-what of an emphasis on consults. When I finished this training, Dr. Sargent had an opening in his department. It was perfect: I could continue to learn from Dr. Sargent, I could continue to teach and enjoy mentoring fellows, and I would learn that Dr. Sargent was also a great boss. He has shown interest in my own interests and developments, even when fostering my own interests was not what Dr. Sargent’s department needed. His door is, figuratively and literally, always open. In fact, it seems like things work best when we junior attendings stay in regular contact with Dr. Sargent. His mentorship and complete selflessness in this endeavor has continued to be wonderful. I really cannot imagine a more generous, selfless, and wise person to have as my primary teacher. Dr. Sargent deserves every honor. And he’s quiet about his own greatness, so he is not likely to seek commendation himself.

Karen Saroca, MD  
Submitted by Ireen Ahmed, MD

It’s not every day you find someone like Dr. Karen Saroca. I met her on my interview day for the Triple Board Program at Tufts Medical Center. From then on, I knew what a special individual she was. When I started my residency, Karen was two years my senior. She mentored me on every-thing from how to plan my schedule, navigating being both a pediatrician and a psychiatrist, to honing my goals as a physician. On a personal level, she taught me how to take care of myself while being a resident, helping me become the person I am today.

Ravi Shankar, MD  
Submitted by Meelie Bordoloi, MD

My mentor has been an extremely important figure in my journey through navigating the treacherous roads of Psychiatry! From guiding me in my academic journey, to lending an empathetic ear during times of stress – he has done it all!! He has also been one of the primary reasons why I entered the field of Child and adolescent Psychiatry. Through this message, I hope to let him know that his presence continues to inspire people around him. Having more mentors like him will only lead to better physicians, ultimately leading to better outcomes for the community at large.

William Stark, MD  
Submitted by Virginia Q. Anthony

In my important formative years with the Academy, William Stark, MD, served as Treasurer. He was reelected twice, making him the longest serving member of the Executive Committee. Bill be-came a presence in the 39 years of my Academy life, and now along with his wife Vivienne is a dear friend. For the six years he served as Treasurer, I learned a lot, a lot about finances, dues collection, and investments. We created the first AACAP budget and started our investments and endowment.

He was a constant in focusing and limiting and direct-ing our agenda. He went on to Chair our Building Committee, and when we bought our home, Regardies, a local business magazine, wrote that the Academy had stolen this building.

Yet I served for 33 years when Bill was not an officer, and we occasionally had lunch... always I learned something. Invariably, he would ask what was going on, and I would share the latest problem and dilemma. Usually, he educated me about what was happening at a deeper level, of-ten asking, WHAT THE HECK IS GOING ON? Bill was an analyst and pushed me to a greater understanding of issues and players. I always learned a lot.

I am so proud to have him as a friend, to still learn from him and still have a lot of fun with him. Bill at age 98 attended his second Lifers dinner this year. I am glad we could share this too.
**Dr. Bruce Sutor**  
*Submitted by Daniel Hosker, MD*

This submission easily constructs itself describing how invaluable of a mentor Dr. Bruce Sutor has been in my development as a clinician and a decent human being. Reflecting on his influence on my training, as I approach the twilight of my adult psychiatry residency, a narration would not do him justice, nor is there the space for such a lengthy explication. Thus, I will attempt to highlight characteristics that come to mind to describe his nature: tireless advocate; unending affability; unwaveringly passionate; uncommonly intelligent; humble practitioner, mentor, and human being; a giant upon whose shoulders I can see farther.

**Cosima C. Swintak, MD**  
*Submitted by Jacquetta Blacker, MD*

Our child and adolescent psychiatry consultant, Dr. Swintak, counselled us during intern orientation, “Pick at least one career mentor who does a job you’d never want to do, just to make sure you’re sure.” I chose her. Six years later and I’m about to graduate child and adolescent psychiatry fellowship. Turns out the career I thought I’d never want was modelled by a compassionate, fiercely passionate, funny, serious, thoughtful woman. She is a warm, dynamic teacher, who helps us realize the best of our potential, and demonstrates daily how to make a difference in children’s and families’ lives.

**Rameshwari Tumuluru, MD**  
*Submitted by Sarah H. Arshad, MD*

Dr. Tumuluru has been an excellent academic, professional, and personal mentor throughout my five years of training. She provides detailed supervision in her partial hospitalization program, and remarkably improved my ability to take histories and conceptualize patients. She serves as a mentor for cultural competency curriculum and programming within residency training. And most importantly, when I became sick and required a week of hospitalization, and when my father later became sick and was intermittently hospitalized for 3-4 months, meeting with her helped keep me grounded and focus on my own wellbeing, while keeping up with my professional duties.

**Laura Whiteley, MD**  
*Submitted by Amy Funkenstein, MD*

For Dr. Laura Whiteley who taught me some of the most valuable lessons in child psychiatry—not to be afraid of the complexity or severity of patients’ illnesses, to skeptically and thoughtfully read the evidence, to creatively build systems of care that meet the needs of patients, and to be brave and honest in every interaction even when your opinion is not the most popular one. More importantly, Laura, thank you for believing in me before I was able to believe in myself, and for sharing your struggles so that I could feel less alone in mine. There is no kinder or more generous gift. For that, and for your indelible black humor that leaves me laughing months after the fact, I will be forever grateful.
AACAP Election Policy
(approved by the Executive Committee March 23, 2001)

The ballot to elect two Councilors-at Large and two Nominating Committee members is mailed in May 2018. The election ends May 31, 2018. 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.

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Jack and Sally McDermott (Dr. Jack McDermott, in memoriam)
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New Research Poster Call for Papers

Deadline: June 15, 2018

AACAP’s 65th Annual Meeting takes place October 22-27, 2018, at the Washington State Convention Center in Seattle, Washington. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry that advance the field and can be used to improve the well-being of children and their families, e.g., clinical treatment, research, training, development, service delivery, administration, translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and suicide and violence prevention. In addition, submissions on depression are encouraged to support AACAP’s current Presidential Initiative.

Verbal presentation submissions were due February 15, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by June 15. The online submission site will open early April. All Call for Papers applications must be submitted online at www.aacap.org/annualmeeting-2018. If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

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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.

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With questions, please contact Samantha Phillips, Communications Manager, at sphillips@aacap.org.
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In Memoriam

Bruce Hauptman, MD
Lexington, MA

Madhvi Richards, MD
East Lansing, MI

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Sahar Alee Koloukani, MD, Roanoke, VA
Shad Syed Ali, MD, Aurora, CO
Jennifer Almendrala, MD, Wexford, PA
Angharad Ames, San Diego, CA
Evelyn Attia, MD, New York, NY
Monique Atwal, Fresno, CA
Anitha Bachireddy, MD, Valhalla, NY
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William E. Kim, MD, Philadelphia, PA
Victoria Lewis, Los Angeles, CA
Rehan Madraswala, MD, Edison, NJ
Alex Mageno, Cincinnati, OH
Faryal Mallick, MD, Jeffersonville, IN
Natasha Mehta, Chicago, IL
Darren Miller, II, Chicago, IL
Lindsay Milliken, Lititz, PA
Shlomit S. Mittler, MD, Ramat Gan, Danielle M. Mohabir, Chapel Hill, NC
Ifeoma Nwugbana, MD, Yonkers, NY
Cristine Oh, Pittsburgh, PA
Marcia Lizank Oliveira Guberman, MD, Grande Colorado, Brasilia
Jessica Patrizi, Greenville, SC
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Jessica Walpole, Columbus, OH
Jonathan Warczak, Rochester, NY
Cassidy Williams, MD, Denver, CO
Jung Yun, Mineola, NY
Xinyi Zhang, MD, Atlantic City, NJ
Clinical Update Recognition

AACAP would like to thank the following members for their exceptional contributions to AACAP’s first Clinical Update, Telepsychiatry With Children and Adolescents:

Kathleen Myers, MD, MPH, MS  
David Pruitt, MD  
Daniel Alicata, MD, PhD  
Patricio Fischman, MD  
Nicole Gloff, MD  
David Roth, MD  
Sharon Cain, MD  
Felissa Goldstein, MD  
Pamela Hoffman, MD  
Jennifer McWilliams, MD  
Ujjwal Ramtekkar, MD  
Lloyd Williamson, MD  
Kristopher Kaliebe, MD

Clinical Updates are a new series of documents intended to address three topic areas: the psychiatric assessment and management of special populations of children and adolescents, the psychiatric assessment and management of children and adolescents in specific settings, and the application of specific psychiatric techniques to children and adolescents. AACAP deeply appreciates the dedication of these authors in the development of this Clinical Update.

The Clinical Update in its entirety was published in the October issue of JAACAP, and is available at www.jaacap.org/article/S0890-8567(17)30333-7/pdf.

Get in the News!

All AACAP Members are encouraged to submit articles and news items for publication, as well as photographs, poems, cartoons, and drawings.

Categories for submission and consideration are:

- **Letters to the Editor**, of 250 words or less, submitted in response to an article published in the AACAP News should be submitted directly to the Editor at urao@mmc.edu or through the National Office to communications@aacap.org. Please include your name and contact information.

- **Photographs** to be published on the front page, inside standing alone, or accompanying relevant articles or stories. Photographs should—in an artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. Members are invited to submit up to two photographs every two months for consideration. Please send a high-resolution version to communications@aacap.org with a description of 50 words or less.

- **Opinion pieces**, including debates, 800-1500 words

- **Articles** approved by and coming from Committees, 600-1200 words

- For a list of column coordinators for Diversity and Culture, Ethics, Acute Care, Clinical Case Reports and Vignettes, Systems of Care, Psychotherapy, and International Relations email communications@aacap.org.

- **Newsworthy items**
  - Fully developed News Articles, 800-1500 words
  - Kudos, highlighting member achievements 250 words or less

- **Regional Organization of Child and Adolescent Psychiatry, 250 words or less**

- **Committee activity reports or updates, 250 words or less**

- **Features, 600-1200 words**

- Interviews
- Discussions of movies or literature
- Creative Arts, e.g. poems, cartoons, drawings (limited to 1 page)
PANS and PANDAS: Sudden Onset of OCD Symptoms

When a child suddenly begins to have new thoughts and unusual behaviors, it can be alarming to parents and family members. If the changes occur suddenly and include unwanted recurring thoughts (obsessions), repetitive behaviors (compulsions), and/or decreased eating, your child’s doctor may consider the diagnosis of Pediatric Acute-onset Neuropsychiatric Syndrome (PANS).

PANS is thought to be triggered by exposure to one of a variety of infections or other things that can activate the immune system. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) is an older and more specific term that describes a sudden development of these symptoms occurring after a strep infection. The understanding of these syndromes is evolving, and doctors may have different opinions about the best assessment and treatment.

In addition to obsessive and compulsive symptoms, PANS can include extreme changes in the following:

- eating
- worrying or anxiety
- mood swings or depression
- irritability, aggression, or oppositional behaviors
- attention, memory, or learning
- sensory or motor problems
- sleep
- bed wetting
- hyperactivity
- tics or movements

Is it OCD, PANS, or PANDAS?

Obsessive compulsive disorder (OCD) is characterized by recurrent intense obsessions and/or compulsions that cause severe distress and interfere with day-to-day functioning. OCD generally develops more slowly over weeks or months. PANS can appear very suddenly.

It is important for parents to understand that PANS and PANDAS are rare. Children get many infections, including strep. Most who get these infections will not develop PANS and PANDAS. Most children who develop OCD symptoms do not have PANS and PANDAS. PANS and PANDAS are new diagnoses relative to most other psychiatric disorders. Researchers are trying to better understand the differences between PANS, PANDAS, and OCD.

Any child who has a sudden change in mood or behavior should be evaluated by a trained and qualified healthcare professional as quickly as possible. If PANS or PANDAS is suspected, it is important to obtain a comprehensive psychiatric and general medical evaluation. This evaluation will begin with a detailed interview with you and your child as well as a physical exam and may be followed by laboratory and other tests. It can be challenging to distinguish between OCD, PANS, PANDAS, and other medical conditions.

After comprehensive assessment with a qualified mental health professional, you should talk to your doctor about treatment. Most children with OCD symptoms can be treated effectively with a combination of psychotherapy, especially cognitive
behavioral therapy (CBT), and selective serotonin reuptake inhibitors (SSRIs) which are the most common medicines used to treat OCD. Family support and education are also central to the success of treatment. Some children with PANS or PANDAS may improve with antibiotics or Intravenous Immunoglobulin (IVIG) treatment. However, these treatments can have serious side effects, and not all studies have shown that they provide a clear benefit. Research is still ongoing; bring your questions to your doctor.

Where can I get more information?

_AACAP’s Facts for Families_

- Obsessive-Compulsive Disorder In Children And Adolescents
- Tic Disorders
- Anxiety and Children
- Delirium in Children and Adolescents
- Comprehensive Psychiatric Evaluation

# # #

If you find _Facts for Families_ helpful and would like to make good mental health a reality, consider donating to the _Campaign for America’s Kids_. Your support will help us continue to produce and distribute _Facts for Families_, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to _Campaign for America’s Kids_, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 9,300 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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If you need immediate assistance, please dial 911.

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Physical Symptoms of Emotional Distress: Somatic Symptoms and Related Disorders

What are Somatic Symptoms?

Physical complaints are common in children. As many as 1 in 10 children will complain of an ache, pain, or worry about their body on any given day. Sometimes when there is no medical illness that fully explains the complaint, it may be that emotions are being felt as physical symptoms. Physical symptoms of emotional distress are called somatic symptoms. Somatization is the name used when emotional distress is expressed by physical symptoms. Everyone experiences somatization at times. Examples include your heart beating fast or butterflies in your stomach when you feel nervous or muscles becoming tense and sore when you feel angry or under stress. These symptoms are very real to your child; they are not “faking it.”

What are Somatic Symptoms and Related Disorders?

A Somatic Symptom and Related Disorder (SSRD) is diagnosed when your child has physical symptoms that are not explained by a medical illness or when symptoms of a known illness affect your child much more than expected and these symptoms interfere with daily life such as missing school, not wanting to play with friends, or avoiding fun activities.

SSRD Symptoms may include:

- body pains including headaches, joint pains
- stomach aches, nausea, vomiting
- fatigue, dizziness, memory problems
- weakness, numbness
- trouble breathing, shortness of breath
- changes in vision or hearing including sudden blindness
- a “stuck” feeling or “lump” in the throat
- seizure-like episodes, fainting, abnormal movements

There are different types of SSRDs. Your child may be diagnosed with: Psychological Factors Affecting a Medical Condition, Somatic Symptom Disorder, or Conversion Disorder (Functional Neurological Symptom Disorder). Terms like “functional,” “nonorganic,” “psychogenic,” “psychosomatic,” “pseudo seizures,” “amplified,” and “medically unexplained” are also sometimes used.

Why does my child have an SSRD?

A child may have an SSRD for many reasons. Sometimes it starts with an illness, injury, or infection, but the symptoms do not go away after the illness has been treated. Other times somatic symptoms start without any prior illness or injury. Somatic symptoms may also be strong feelings or struggles that a child has not been able to share in words. When a child’s feelings build up inside, their body may express those feelings physically.

How are SSRD diagnoses made?

Varied professionals including your child’s primary care provider, pediatric specialists (for example, neurologists or gastroenterologists), child and adolescent psychiatrists, and pediatric psychologists may be involved in the assessment, diagnosis, and treatment.
The evaluation typically involves:

- an evaluation of physical, emotional, and behavioral symptoms and daily functioning
- a physical exam
- reviewing the results of medical tests (lab work, imaging, or procedures)

How are SSRDs treated?

SSRDs are treatable. Sometimes symptoms are short-lived and disappear quickly without treatment. Other times, a child needs a course of treatment. Psychotherapy (talk therapy) focusing on helping a child express feelings is very important. The main goal of treatment is to help a child return to normal levels of functioning.

Treatment will be based on the needs of your individual child and may include:

- Psychotherapy to help understand the connection between feelings and physical symptoms and to teach skills like breathing exercises, relaxation, and biofeedback
- Physiotherapy and occupational therapy to help muscle strength and movement
- Actions to relieve physical discomfort such as massage, ice, or heat
- Small, gradual steps to improve function
- Return to school with the help of school accommodations and support from teachers, nurses, and school counselors
- Return to after school activities as soon as possible (e.g. spending time with friends, sports, clubs)
- Regular check-ins with your health care team to check for improvements and any new treatment changes

What can I do to help my child?

As a family member, you are an important member of the treatment team; you know your child best and can help others understand your child.

Ways you can help include:

- Asking for medical and behavioral health providers who understand the mind body connection
- Encouraging new ways for your child to talk about uncomfortable feelings
- Helping your child practice coping and relaxation strategies
- Supporting your child’s efforts to focus less on physical symptoms
- Working with school and other programs to help your child return to usual activities as soon as possible
- Helping your own anxiety that may develop, as a concerned parent or other family member

Where can I get more information about SSRDs?

AACAP’s Facts for Families

- Chronic Illness and Children
- Disaster: Helping Children Cope
- Stress Management and Teens
- Anxiety and Children
- School Refusal
- When to Seek Help for Your Child
- Where to Find Help for Your Child

This website has information about somatic symptoms and the mind body connection, including a 20-minute video.

# # #
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Call for Papers and Children’s Artwork

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.
AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

Conversion Therapy

Variations in sexual orientation and gender expression represent normal and expectable dimensions of human development. They are not considered to be pathological; therefore, they are not included in the Diagnostic and Statistical Manual of Mental Disorders, and other accepted nosological systems.¹ Health promotion for all youth encourages open exploration of all identity issues, including sexual orientation, gender identity, and/or gender expression according to recognized practice guidelines.² This fosters healthy development, especially for sexual and gender diverse youth, as they integrate their sexual orientation, gender identity, and/or gender expression, into their overall identity without any pre-determined outcome.

“Conversion therapies” (or “reparative therapies”) are interventions purported to alter same-sex attractions or an individual’s gender expression with the specific aim to promote heterosexuality as a preferable outcome.³,⁴ Similarly, for youth whose gender identity is incongruent with their sex anatomy, efforts to change their core gender identity have also been described and more recently subsumed under the conversion therapy rubric.⁵ These interventions are provided under the false premise that homosexuality and gender diverse identities are pathological. They are not; the absence of pathology means there is no need for conversion or any other like intervention. Further, there is evidence that “conversion therapies” increase risk of causing or exacerbating mental health conditions in the very youth they purport to treat.²-⁵

Comprehensive assessment and treatment of youth that includes exploration of all aspects of identity, including sexual orientation, gender identity, and/or gender expression is not “conversion therapy.”² This applies whether or not there are unwanted sexual attractions and when the gender role consistent with the youth’s assigned sex at birth is non-coercively explored as a means of helping the youth understand their authentic gender identity. In the presence of gender dysphoria (distress related to the incongruence between gender identity and sex assigned at birth), the standard of care may involve exploration of living in a different gender role (appropriate to the child or adolescent’s developmental understanding of gender) and/or potential use of affirming gender transition interventions to align anatomical features with one’s gender identity for appropriately assessed pubertal adolescents.⁶,⁷ This follows recognized standards of care and is not considered “conversion therapy.”

The AACAP Policy on “Conversion Therapies”

The American Academy of Child and Adolescent Psychiatry finds no evidence to support the application of any “therapeutic intervention” operating under the premise that a specific sexual orientation, gender identity, and/or gender expression is pathological. Furthermore, based on the scientific evidence, the AACAP asserts that such “conversion therapies” (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful. As a result, “conversion therapies” should not be part of any behavioral health treatment of children and adolescents. However, this in no way detracts from the standard of care which requires that clinicians facilitate the developmentally appropriate, open exploration of sexual orientation, gender identity, and/or gender expression, without any pre-determined outcome.
References:


For more information or to review AACAP’s Policy Statements visit [www.aacap.org](http://www.aacap.org).
AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

Off-Label Prescribing

The definition of “off-label” is the specific administration of a medication for a use that is not included in the FDA package insert for that medication. Thus, medications may be used for different age groups, doses, and duration that are not specifically addressed in the product labeling. Further, combination treatment is not commonly covered by product labeling including: treating comorbid psychopathology, when monotherapy is ineffective, or to help lessen the adverse effects of another medication. While there are FDA approved combination treatments, most combinations are considered off-label use.

For some indications, “older” medications may have FDA approval based on a prior approval process that used extrapolation from adult studies as opposed to pediatric testing. However, “newer” treatments may be preferred due to efficacy and/or tolerability as determined via pediatric research. Another increasing use of “off-label” medications is when youth exhibit impairment but do not meet threshold criteria for a specific disorder. Those children with subthreshold symptoms for approved disorders have impairment and can benefit greatly from treatment with medication that has proven efficacy in the disorder.

AACAP’s website contains a toolkit for monitoring symptoms and response to medications. A parent AACAP resource is the Parents Medication Guide series covering use of medications for psychiatric disorders.

Off-label medication use is part of the standard of care in the treatment of psychiatric disorders when: 1) there is a solid evidence base for the medication, 2) an off-label medication has better efficacy and/or safety evidence than an on-label one, 3) a child has symptoms that are not controlled by, or experiences unacceptable side effects due to, an on-label medication, 4) a child has a disorder or comorbid conditions for which there is no FDA-approved treatment, 5) adjunct medication is necessary for control of side effects of another medication, and/or 6) a child is below the age for which an FDA approved treatment is available.

References:


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

AACAP Policy Statement Requirements

Policies should:

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

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

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

Policy Statement Procedures

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

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

  OR

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

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

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

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

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

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

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

*revised 10/2012
AACCAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. Thank you to the following donors for their generous financial support of our mission.

Gifts Received January 1, 2018 to February 28, 2018

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Bryan John Bergh, MD
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Ravinder Bhalla, MD

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org.
2018 CATCHERS IN THE RYE AWARDS
Recognizing and promoting advocacy for children

The Catchers in the Rye Awards are AACAP’s most prestigious awards that recognize an AACAP member, an AACAP component, and a regional organization of the AACAP Assembly for outstanding advocacy efforts. In terms of the award:

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

AACAP recognizes advocacy in three categories:

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

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

Awards will be presented at the Assembly’s fall meeting during AACAP’s Annual Meeting in Seattle, WA, October 2018. Please forward your nominations to:

Grace Titgemeier, Executive Office Coordinator
AACAP
3615 Wisconsin Avenue NW
Washington, DC 20016
or email to gtitgemeier@aacap.org

Nominations due by June 30, 2018

The Assembly Catchers in the Rye Selection Committee serves as the reviewing body that makes recommendations to the Assembly Executive Committee who selects the final awardees. The committee consists of a Past Assembly Chair, one Delegate representative from each U.S. zone, an ECP Delegate, and a past recipient of the Catchers award (i.e. individual, committee member, or RO officer affiliated with the Assembly. The award name derives from Dr. John Schwalter’s Presidential Address in which he alluded to J.D. Salinger’s book and Holden Caulfield’s response to what he wanted to be when he grew up . . .

“I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around -- nobody big, I mean -- except me. And I am standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff.”
AAPAC AWARDEE SPOTLIGHT:
Suzan Song, MD, MPH, PhD

Attending my first AACAP Annual Meeting in Hawaii is likely the reason why I continue to be an active member. I remember being intimidated and confused about what sessions to attend, and how to best use the conference time. I found the mentorship and guidance through the EOP supportive and generous, making me want to be more involved not only in the organization, but also in child psychiatry. This is where I learned of the impact of mentorship, and it has directly influenced my current position, where I provide career mentorship for medical students and residents with an interest in child psychiatry.

2011 AACAP PILOT RESEARCH AWARDEE

Project Title: “The Importance of Family: Intergenerational Stress in Burundian Former Child Soldiers”

I examined how the experience of being a child soldier (at the individual and societal levels) affect parenting practices and their children’s mental health. Understanding the influences of perpetrating violence on the relationship with one’s child and family, can lead to early prevention/intervention programs for children of child soldiers who may have mental health needs.

Funding for this feasibility study was the start of my research career. Prior to this, I was focused on clinical work, and had never really conducted a study independently. This study fostered my interest in pursuing research more seriously, to the point of completing a post-doctoral research fellowship and PhD on the topic. This single award allowed me to take a simple question and turn it into a career, that also ultimately led to my position as a humanitarian protection advisor for the United Nations.

ABOUT DR. SONG

JOINED AACAP: DECEMBER 2009

WORKS AT: GEORGE WASHINGTON UNIVERSITY

POSITION: DIRECTOR, DIVISION OF CHILD, ADOLESCENT, AND FAMILY PSYCHIATRY; ASSOCIATE PROFESSOR;

SPECIALTY AREAS: COMMUNITY MENTAL HEALTH, CULTURAL PSYCHIATRY, GLOBAL MENTAL HEALTH

AACAP AFFILIATIONS

COMMITTEE WORK
Child Abuse and Neglect Committee
International Relations Committee

The Child Abuse and Neglect Committee was the first committee I had participated in. I was impressed and inspired by the dedication of CAPs to the well-being of children, through an interweaving of clinical experience, research, and policy. I currently am a member of the International Relations Committee, where I organize panels that educate about the issues of children and families in migration, as well as solicit articles for AACAP News that highlight issues involving CAPs from around the world.

REGIONAL WORK
Greater Washington Society
Northern California Regional Organization

I am thankful to have joined the Northern CA Regional Organization, first as Vice President, then as President. It was quite a learning curve, of how to prioritize local issues and keep the interest of CAPs in the region, while also working with the larger AACAP community. As Vice President, I organized our annual conference on global mental health - bringing global work to local issues. I have recently moved to the Washington, DC area and look forward to learning from and engaging with new colleagues.
AACAP Award Opportunities
FOR MEDICAL STUDENTS, RESIDENTS, AND EARLY CAREER PSYCHIATRISTS

RESIDENTS AND JUNIOR FACULTY

AACAP Pilot Awards
Application Deadline: March 30, 2018
Provides $15,000 to members with a career interest in child and adolescent mental health research

Research Award for Child and Adolescent Psychiatry Residents and Junior Faculty, Supported by AACAP
Research Award for Child Psychiatry Residents and Junior Faculty focusing on Attention Disorders and/or Learning Disabilities, Supported by AACAP’s Elaine Schlosser Lewis Fund
Research Award for General Psychiatry Residents, Supported by Industry Supporters

AACAP Educational Outreach Programs (EOP)
Application Deadline: July 13, 2018
Provides travel support of up to $1,000 for Residents and CAP Fellows to travel to AACAP’s Annual Meeting and network with leaders in the specialty

EOP for Child and Adolescent Psychiatry Residents, Supported by AACAP’s Endowment Fund, AACAP’s John E. Showalter, MD, Endowment Fund, and AACAP’s Life Members Fund
EOP for General Psychiatry Residents, Supported by AACAP’s Endowment Fund

AACAP Systems of Care Special Program Clinical Projects Scholarship, Co-sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee
Application Deadline: July 13, 2018
Provides support of $750 to attend AACAP’s Annual Meeting and present a poster on a systems-of-care-related topic

AACAP Junior Investigator Award, Supported by AACAP
Application Deadline: March 15, 2018
Provides $30,000 a year for two years for one child and adolescent psychiatry junior faculty

RESIDENTS

Medical Student Fellowships
Provides a $3,500 to $4,000 stipend for 12 weeks of research training and covers travel expenses for AACAP’s Annual Meeting

AACAP Jeann Spurlock Minority Medical Student Research Fellowships in Substance Abuse and Addiction, Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign forAmerica’s Kids (CFAK)
Extended Application Deadline: March 15, 2018
AACAP Summer Medical Student Fellowship Program, Supported by AACAP’s CFAK
Application Deadline: March 2, 2018

*All awards contingent upon available funding.

For more information, visit www.aacap.org/awards.
AACAP Cancro Academic Leadership Award recognizes, in even-numbered years, a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of a Department of Pediatrics, or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry.

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

AACAP Irving Philips Award for Prevention recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents.

AACAP Jeanne Spurlock Lecture and Award on Diversity and Culture recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in children’s mental health, and who contribute to the recruitment into child and adolescent psychiatry from all cultures.

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

AACAP Sidney Berman Award for the School-Based Study and Treatment for Learning Disorders and Mental Illness recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness.

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

Academic Paper Award Opportunity
Application Deadline: May 1, 2018

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

International Scholar Award Opportunities
Application Deadline: June 15, 2018

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

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

For details about all awards, eligibility requirements, and for access to applications and nomination information, visit www.aacap.org/awards.
Child and Adolescent Psychiatrist

The Commonwealth Center for Children & Adolescents (CCCA) invites you to consider a Child and Adolescent Psychiatry position in the beautiful Shenandoah Valley. CCCA is Virginia's only public acute psychiatric hospital for children and adolescents. CCCA is a 48-bed hospital serving youngsters with a variety of serious psychiatric disorders from across the state of Virginia. Treatment is provided in a relationship-based, collaborative, trauma-informed treatment model of care, in which the psychiatrist is the head of the child's treatment team on a 12-bed unit.

As Psychiatrist, you will direct a multidisciplinary treatment team consisting of a psychologist, social worker, nurse, substance abuse counselor, direct care staff, and teachers, providing treatment for children and adolescents with complex, co-morbid, and severe mental illnesses. Expertise in psychiatric evaluation and treatment, including psychopharmacology, is essential.

CCCA serves as the inpatient child psychiatry training center for the University of Virginia Department of Psychiatry and Neurobehavioral Sciences child psychiatry fellows and general psychiatry residents, and abundant education and supervision opportunities are available, including a clinical faculty appointment at the University of Virginia for eligible candidates.

For further requirements and to apply, please visit the Virginia Jobs at [http://jobs.virginia.gov/](http://jobs.virginia.gov/). The position offers a competitive salary with full state benefits including vacation and educational conference time, retirement plan, medical and dental insurance, disability plan, life insurance, etc. Position also offers generous sign on bonus, relocation package, CME allowance, substantial student loan repayment, and generous on-call stipend.

Please contact our Human Resource office at (540) 332-2116 for further questions.

CCCA is an equal opportunity, affirmative action employer.
CLASSIFIEDS

CALIFORNIA

CHILD AND ADOLESCENT PSYCHIATRIST
(San Diego, CA)

Job Description:
The Department of Psychiatry at University of California, San Diego is recruiting for early and mid career child and adolescent psychiatrists to join our growing faculty cohort in our outpatient, telemental health, and community psychiatry programs. We are a strong program with world class research, teaching and innovative programs. The Community Psychiatry Program focuses on training Residents, Psychiatric Nurse Practitioner Students, and Allied Mental Health Students in community based settings, working in unique practice models (such as wraparound services, residential treatment, and integrated care) and with specialized populations (including but not limited to homeless youth, LGBTQ youth and transitional age adults, youth facing psychiatric crises, children and families with undiagnosed mental illness). Psychiatrist will have opportunities to work with our well-established community partners, help foster new relationships with outside training sites, supervise fellow trainees and provide direct clinical care to underserved youth and their families. The ideal match is dedicated to providing excellent clinical care in the public sector. If you are seeking a unique position in sunny San Diego, with its great weather and beautiful beaches, we hope you join our team at UCSD.

For more information, please contact Jason Schweitzer, MD, MSW jaschweitzer@ucsd.edu or Steve Koh, MD, MPH, MBA, at shkoh@ucsd.edu

Job Requirements:
Board Eligible/Completed training at accredited CAP Fellowship

Company: University of San Diego California (1079760)
Job ID: 10656446
http://jobsource.aacap.org/jobs/10656446

ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
(San Bernardino County, CA)

Job Description:
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursuing dreams, creating hope and driving progress. While every physician at the Southern California Permanente Medical Group has their own personal and professional ambitions, they all share a common vision: to transform the practice of medicine. Every day, they work hand in hand—with each other and their patients—to achieve outcomes that elevate the level of care across our organization and, ultimately, our nation.

ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
San Bernardino County, California. Our San Bernardino County location offers spectacular natural scenery and an exceptional climate. Ideally situated near Big Bear and Lake Arrowhead, you’re 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 physicians enjoy: 4 1/2 day work week (8-10 hours) Options for flexible schedules Education time (1/2 day) Academic teaching opportunity available through our Adult Residency Program Bonuses offered Research opportunities Team model – MA, LCSW, Psychologists Child and Adolescent Fellowship opened in the summer of 2017 In clinic consult model available in the Chino/Grand facility (embedded in Primary Care). 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. You’ll love coming home to Southern Central California.

http://scpmgphysiciancareers.com

Company: Spin Recruitment Advertising (876472)
Job ID: 10801262
http://jobsource.aacap.org/jobs/10801262

CHILD AND ADOLESCENT PSYCHIATRISTS
(Kern County, CA)

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 Southern Central California’s recreational heartland, Kaiser SCPMG is proud to offer its physicians: An organization that has served the communities of Southern California for more than 60 years Stability during times of change in health care nationwide A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration An environment that promotes excellent service to patients Comprehensive administrative support A fully implemented electronic medical record system 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://scpmgphysiciancareers.com. For questions or additional information, please contact Jolanta Buschini at (877) 259-1128 or Jolanta.U.Buschini@kp.org.

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Company: Spin Recruitment Advertising (876472)
Job ID: 10801272
http://jobsource.aacap.org/jobs/10801272

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CHILD AND ADOLESCENT PSYCHIATRISTS AND ADULT PSYCHIATRISTS
(Riverside, CA)

Job Description:
I am a PERMANENTE PHYSICIAN. A skilled practitioner who seeks to create high-quality outcomes through integrated care. 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. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS Openings in Riverside, California. 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. Kaiser SCPMG is proud to offer its physicians: An organization that has served the communities of Southern California for more than 60 years A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration Comprehensive administrative support An environment that promotes excellent service to patients A fully implemented electronic medical record system An excellent salary, comprehensive benefits and partnership eligibility 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://scpmpphysiciancareers.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
Job ID: 10801277
http://jobsources.aacap.org/jobs/10801277

ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
(San Bernardino County, CA)

Job Description:
I am a PERMANENTE PHYSICIAN. A dedicated doctor who believes in pursuing dreams, creating hope and driving progress. While every physician at the Southern California Permanente Medical Group has their own personal and professional ambitions, they all share a common vision: to transform the practice of medicine. Every day, they work hand in hand—with each other and their patients—to achieve outcomes that elevate the level of care across our organization and, ultimately, our nation. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS San Bernardino County, California. Our San Bernardino County location offers spectacular natural scenery and an exceptional climate. Ideally situated near Big Bear and Lake Arrowhead, you’re 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 physicians enjoy: 4 1/2 day work week (8-10 hours) Options for flexible schedules Education time (1/2 day) Academic teaching opportunity available through our Adult Residency Program Bonuses offered Research opportunities Team model - MA, LCSW, Psychologists Child and Adolescent Fellowship opened in the summer of 2017 In clinic consult model available in the Chino/Grand facility (embedded in Primary Care). If you believe in pursuing dreams, creating hope and driving progress, then you’re the very definition of a Permanente Physician.

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The Answer to Health Care in America.

Company: Spin Recruitment Advertising
Job ID: 10801283
http://jobsources.aacap.org/jobs/10801283

ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS
(Southern California)

Job Description:
I am a PERMANENTE PHYSICIAN. Building a future for my career, my family and my community. 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. ADULT PSYCHIATRISTS AND CHILD AND ADOLESCENT PSYCHIATRISTS Openings throughout Southern California 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. Kaiser SCPMG is proud to offer its physicians: An organization that has served the communities of Southern California for more than 60 years A physician-led practice that equally emphasizes professional autonomy and cross-specialty collaboration Comprehensive administrative support An environment that promotes excellent service to patients A fully implemented electronic medical record system An excellent salary, comprehensive benefits and partnership eligibility 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.

**GEORGIA**

**CHILD/adolescent psychiatry FEE FOR SERVICE PRIVATE PRACTICE**

(Atlanta, GA)

**Job Description:**
PPP is seeking a full-time BC/BE Child/adolescent psychiatrist to join a well-established Atlanta practice in the Buckhead area, which consists of six board certified psychiatrists (3 Child/Adol), all Emory trained and instituting psychopharmacology and psychotherapy. The practice has several licensed therapists and psychologists who collaborate with physicians and offer outstanding clinical care. PPP administrative staff members offer full service to physicians. The practice provides a highly competitive salary structure, malpractice insurance, full benefits with matching 401K, and the ability to control your own scheduling. There is the option to refer for TMS and DBT treatment within our own practice, along with other specialized treatment modalities. A Georgia medical license and DEA and NPI numbers are required. If interested, please submit Cover Letter and Curriculum Vitae.

**Company:** Peachtree Psychiatric Professionals (1080623)
**Job ID:** 10669941
http://jobsource.aacap.org/jobs/10669941

**MARYLAND**

**PSYCHIATRY FACULTY, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY FEE FOR SERVICE PRIVATE PRACTICE**

(Baltimore, MD)

**Job Description:**
The Johns Hopkins University Department of Psychiatry, Division of Child and Adolescent Psychiatry is seeking either child and adolescent psychiatrists or psychologists committed to a career in academic medicine. Successful candidates will be superb clinicians or investigators committed to improving the lives of children and adolescents suffering from psychiatric disorders through direct patient care, research, and/or education. Open rank, clinical and research faculty appointments within the Department of Psychiatry and Behavioral Sciences are available commensurate with background and experience. Positions have the potential to provide a mixture of clinical, teaching and research opportunities dependent upon interest and skills of the faculty member. Leadership opportunities are available. The Johns Hopkins University provides excellent benefits including partial college tuition grant for dependents (at any college) and tuition remission for faculty members, spouses, and dependents for coursework completed at the Johns Hopkins University and Peabody Music Institute. The Johns Hopkins University is an equal opportunity/affirmative action employer committed to recruiting, supporting, and fostering a diverse community of outstanding faculty, staff, and students. All applicants who share this goal are encouraged to apply.

Contact: Robert Findling, MD, MBA, Director, Child and Adolescent Psychiatry, The Johns Hopkins University School of Medicine
Phone 410-955-2320
Email: rfindli1@jhmi.edu

**Job Requirements:**
Board-Certified or Eligible in Child and Adolescent Psychiatry; Licensed Clinical Psychologist

**Company:** Johns Hopkins University (937702)
**Job ID:** 10713015
http://jobsource.aacap.org/jobs/10713015
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November/December 2018 . . . September 27, 2018
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