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

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

Early Bird Registration Deadline: **September 12, 2019**

Visit [www.aacap.org/AnnualMeeting-2019](http://www.aacap.org/AnnualMeeting-2019) for the latest information!
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**Cover:** Each year we try and capture the incredible enthusiasm the membership has for our Legislative Conference. This picture was taken on the steps of the Capitol. A big thank you for all attendees – especially the family members that came to DC to make a difference! – Photo by Rob Grant
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

MISSION OF AACAP NEWS
The mission of AACAP News includes:
1. Communication among AACAP members, components, and leadership.
2. Education regarding child and adolescent psychiatry.
3. Recording the history of AACAP.
4. Artistic and creative expression of AACAP members.
5. Provide information regarding upcoming AACAP events.
6. Provide a recruitment tool.

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AACAP Election Results

AACAP’s 2019 election concluded on May 31 at 11:59:59 pm EDT. On behalf of AACAP, thank you to everyone who voted in this important election.

Please join me in congratulating the following members whose terms begin in October 2019 at the end of the Annual Meeting in Chicago, IL:

- **President-Elect (October 2019-October 2021)**
  Warren Y.K. Ng, MD, MPH

- **Secretary (October 2019-October 2021)**
  Cathryn A. Galanter, MD

- **Treasurer (October 2019-October 2021)**
  Bennett L. Leventhal, MD

- **Councilors-at-Large (October 2019-October 2022)**
  Adrienne L. Adams, MD, MSc
  Anita R. Kishore, MD

- **Nominating Committee (October 2019-October 2021)**
  Eraka Bath, MD
  John Sargent, MD

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

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

Sincerely,

Karen Dineen Wagner, MD, PhD
President

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

Ballots will be held for three months after the election, during which time anyone who wishes to contest the election can do so. After three months the ballots will be destroyed.

*Campaigning is prohibited in AACAP elections.*
Case Study:
Alex is a 17-year-old female with major depression, anxiety disorder, and borderline intellectual disability who was admitted to an adolescent psychiatric unit with worsening isolation and neurovegetative symptoms. A significant symptom of her depression is psychomotor slowing and markedly diminished motivation and interest in most daily activities, including poor completion of activities of daily living (ADLs). Alex often wears the same clothes and rarely showers. Her peers complain of her body odor, further estranging Alex from the community as well as worsening her depression and self-esteem. Over the course of her hospital stay, Alex begins to sleep through the day, avoiding groups and complaining “groups are too repetitive.”

The Acute Care Setting
The landscape of inpatient psychiatry has changed over recent decades. Psychiatric hospitalizations are now characterized by shorter lengths of stay (LOS) and less individual time with therapists. For psychiatrists, shorter LOS have led to greater pressure to acutely stabilize, refer, and discharge patients. As the LOS decreased, the structure and rehabilitation programming for the patients transformed to focus more specifically on stabilization, education, and creating routine and structure.

However, there remains a small cohort of patients who are hospitalized for extended periods of time. It is common for these patients to have chronic and severe symptoms that can be difficult to manage such as treatment-resistant depression, cognitive impairments, and failure to meet developmental milestones, all of which impact self-care and independent functioning. Often, long-term patients will struggle with their extended stay within the construct of modern milieu treatment which is designed for acute admissions, resulting in a withdrawal from routine programming. Furthermore, patients may even regress: they might isolate themselves in their room, have excessive daytime somnolence, or stop performing ADLs. While hospitals may be limited by their short-term programming, there remains an opportunity to combat these short-comings. An occupational therapist (OT) can provide unique contributions as part of the treatment team, improving patient experiences and hospital outcomes.

Back to Alex: The Impact of OT on Individual Treatment
With our patient Alex, the OT employed a stepwise plan to help reverse her cycle of depression, social isolation, and poor self-care. This approach began with an emphasis on basic ADLs to improve her personal hygiene, and then progressed to practicing social interaction with peers on the unit, and later expanded to improving Alex’s skills to deal with challenges faced in the real world.

On initial assessment, the OT identified Alex’s lack of ADLs as not only a symptom of her depression but also a significant driver of her social isolation and poor self-esteem. To address her poor personal hygiene, the OT began by taking the patient into the bathroom to review essential aspects of self-care, demonstrating to Alex basic hygiene practices like how to wash her face, brush her teeth, and engage in occupations. Occupations in this context refer more broadly to meaningful activities, incorporating ADLs/iADLs, hobbies, and education in addition to employment. In the inpatient setting, occupational therapists first assess the individuals’ strengths, habits, abilities (cognitive, motor, social), and roles and routines in the community, identifying areas in his/her life that could benefit from change. The occupational therapist will then create a plan for opportunities to integrate meaningful activities into the various aspects of daily living while in the hospital. This treatment plan should parallel roles and represent activities outside the hospital, for example, performing daily hygiene, weekly laundry, calling one’s school advisors, scheduling homework time, etc. Goals are formulated while understanding the limitations of what can be accomplished in this setting, given the acute exacerbation in mental health symptoms and the artificial environment of a hospital.

What is an OT anyways?
Occupational therapists are qualified mental health professionals with formal education in occupational sciences, psychology, psychiatry, sociology, neuro-psychology, anatomy, and physiology. The profession of occupational therapy was founded in psychiatry, and their role on the team rests on the fundamental view that all humans have a desire to engage in occupations. Occupations in this context refer more broadly to meaningful activities, incorporating ADLs/iADLs, hobbies, and education in addition to employment. In the inpatient setting, occupational therapists first assess the individuals’ strengths, habits, abilities (cognitive, motor, social), and roles and routines in the community, identifying areas in his/her life that could benefit from change. The occupational therapist will then create a plan for opportunities to integrate meaningful activities into the various aspects of daily living while in the hospital. This treatment plan should parallel roles and represent activities outside the hospital, for example, performing daily hygiene, weekly laundry, calling one’s school advisors, and scheduling homework time, etc. Goals are formulated while understanding the limitations of what can be accomplished in this setting, given the acute exacerbation in mental health symptoms and the artificial environment of a hospital.

Matthew B. Bolton, MOT, OTR/L, Zachary M. Harvanek, MD, PhD, and Hun Millard, MD
appropriately apply makeup. They created a written hygiene plan together that Alex could follow in the mornings. With the implementation of this hygiene plan, Alex began receiving positive feedback from her peers and became more social on the unit.

The OT recognized this as evidence Alex would now benefit from improving her social skills. Alex was encouraged to invite peers on the unit to play games such as Ping-Pong with her. The OT and Alex would hold sessions after these games to debrief and identify specific, achievable goals for her next session, such as asking follow-up questions. These sessions allowed development of social skills to help combat the social isolation that was both a symptom of and contributor to her mental health issues.

As Alex and the OT continued their work together, Alex frequently mentioned her desire to learn “adult things” like cooking. The OT utilized this as an opportunity to teach Alex real-world skills, such as how to safely use an oven. After working with OT, Alex made chocolate chip brownies, and shared them with the unit, building her self-esteem while also teaching her iADLs that will be useful after discharge.

As Alex started to increase her engagement in the typical group programing, the OT focused on other skills she would require to maintain her recovery after discharge, including creating a daily schedule, balancing schoolwork and free time, and social media use. The OT and Alex visited various social media sites together to practice appropriate online interactions, such as not responding to cyber bullying. These skills were consciously reinforced during these activities by requiring Alex to verbalize different safe practices when they arose, such as “not threatening people when they hurt my feelings.”

The Impact of OT on Milieu Treatment

The presence of the OT on Alex’s care team allowed for focused assessment of and then intervention on her habits, social abilities, and life skills as they related to Alex’s mental health. In the modern psychiatric unit, this is a domain distinct from that of other members of the care team, where the focus is often on medication management, individual psychotherapy, and family therapy. As most patients in an inpatient setting have difficulties with these practical skills, OTs’ skills are applicable from broad group settings to specific, individualized interventions.

Occupational therapists make effective group therapists, providing skilled interventions focused on increasing a patient’s ability to independently cope with their symptoms and engage in meaningful activities. For example, OTs run a variety of groups including CBT and DBT, life skills, and sensory modulation. Given the OT’s unique assessment of each patient, they frequently alter group activities based on the needs and abilities of the individuals and how they function as a collective group, and in settings where patients have a choice of which group to attend, OTs can match patients with groups at the appropriate functional level. This provides interventions that maximize benefit to the group without overwhelming individual members. Ensuring all patients are challenged to the appropriate level can reduce the amount of behavioral issues, helping to maintain a positive environment in the milieu.

OTs also help maintain unit structure by enabling patients to create their own roles, routines, and habits on the unit, giving patients a sense of control. In patients with highly individualized needs, OTs can also be called on for consulting purposes; they can help evaluate a patient’s functional cognition, and practical living skills to make discharge recommendations. This often allows for providers to advocate for unique and more intensive outpatient services. OTs may also prove beneficial as case managers given their knowledge of a patient’s community-based supports, familial circumstances, and personal needs.

Conclusion

As trends in acute psychiatry continue to lean towards short-term hospitalizations, ensuring client-centered care for all patients can be extremely difficult. Patients who are hospitalized for extended periods of time often face
What’s OT Got To Do With It continued from page 167

unique challenges, and can be difficult to engage. Thankfully, having an occupational therapist on staff can be a powerful tool to engage these patients, while providing rich information for the treatment team and increasing positive hospitalization outcomes. OTs can also be instrumental in maintaining a positive milieu, running groups, and in discharge planning. Which leads to one question, what can an OT do for your treatment team?

References

The Chicago River is the only river in the world that flows backwards.

For more information on CASII, contact the Clinical Practice Program Manager at clinical@aacap.org.
Catatonia: Treatment with a Benzodiazepine

1) What exactly is catatonia? I know it is a collection of particular symptoms but as an entity, is it a disorder and thus a comorbidity (e.g. schizophrenia AND catatonia; autism AND catatonia) or a modifier like psychosis is to mania or depression?

Catatonia is a distinct neuropsychiatric syndrome, characterized by a variety of motor, speech and behavioral symptoms. DSM-5 classifies catatonia as a symptom-complex associated with a range of psychiatric disorders, but also includes it as a condition that may exist without a clear psychiatric or medical condition (catatonia NOS). The DSM-5 lists twelve discrete catatonic symptoms irrespective of the associated psychopathology or a medical condition, with any three required for the diagnosis. Thus, catatonia may be regarded both as a symptom associated with another axis I psychiatric or a medical disorder, and as a stand-alone syndrome with its own unique symptoms, complications and treatment response.

Motor symptoms of catatonia may include a change in the baseline level of activity (ranging from stupor to frenzied excitement that can include aggression and self-injury); episodic cessation of all activity (known as freezing, pausing or “getting stuck,” often associated with a reduced blink rate and staring); semi-purposeful repetitive movements (movements are abnormal primarily due to their frequency; also known as stereotypies) and may involve any part of the body including fingers, hands, arms or the trunk; tics; catalepsy (a sudden change in motor tone); rigidity; echopraxia and facial grimacing (abnormal facial movements of the eyes, nose and/or mouth resembling a grimace).

Speech symptoms of catatonia may include a total loss of speech or mutism, reduced meaningful speech, nonsensical speech (verbligeration), echolalia and/or perseverative repetitive speech (repeating a word or a sentence, often multiple times). Behavioral symptoms may include anxiety, mood symptoms (both elevated or depressed mood), reduced sleep, withdrawal or an unwillingness to participate (known as negativism; this symptom includes a motor and a behavioral component resulting in senseless refusal to participate including in previously enjoyed activities), and psychosis-like or frank psychotic symptoms involving auditory or visual modalities.

Regression or loss of previous skill level is commonly present. High frequency self-injurious behavior devoid of operant function and resistant to environmental modification is now regarded as a symptom of catatonia (Wachtel and Dhossche 2010).

Catatonia has an interesting history. It was first described by Kahlbaum in 1874, who presented a unitary view of the condition which was not historically shared by all psychiatrists. In their book, Catatonia (American Psychiatric Pub, 2007) Caroff et al. assert that for many years “the syndrome of catatonia became a step child of clinical psychiatry and for a while it disappeared into oblivion.” Extensive historical accounts describe how catatonia became erroneously associated with dementia praecox and later with schizophrenia, resulting not only in faulty clinical diagnosis, but also the inappropriate prescription of antipsychotic agents for many patients with catatonia resulting in negative outcomes. Indeed, antipsychotics may precipitate or worsen catatonia, including its malignant form which can be fatal.

An increased interest in catatonia has been observed across the psychiatric profession in recent years, and may have resulted from the relative frequent comorbidity of catatonia in patients with autism (and possibly other developmental disorders) (Lorna Wing and Amitta Shah 2006). Indeed, catatonia is estimated to occur in 12-18% of autistic patients.

Catatonia is exquisitely responsive to benzodiazepines (BNZ) and electroconvulsive therapy (ECT), yet generally does not respond to antidepressants, antipsychotics or mood stabilizers regardless of comorbidity (Fink et al. 2006; Dhossche and Wachtel 2010). Malignant catatonia is associated with dangerous thermo-regulatory and hemodynamic instability, and may present among acutely ill psychiatric patients, often resembling an infective illness but without findings that support the presence of an infection.

Although catatonia is not a novel disorder, its timely recognition, treatment and associated research have been undermined over years due to its misclassification as a subtype of schizophrenia and other historical reasons including ECT-associated stigma (Fink et al. 2010).

2) In what patient populations are you most likely to see it?

Catatonia occurs across gender and throughout the life span, and in those with typical development as well as with development delays. Common comorbidities of catatonia are affective and psychotic disorders, although there are myriad psychiatric, neurological, somatic and drug-related etiologies to the syndrome. Although there is a paucity of systematic studies, continued on page 170
Catatonia: Treatment with a Benzodiazepine continued from page 169

approximately one in five patients with autism develop this condition around puberty, while the condition appears to be less common in patients with typical development (L. Wing and A. Shah 2006). Furthermore, about 10% of acutely ill psychiatric patients may meet criteria for catatonia (Rosebush and Mazurek 2010). Current knowledge demonstrates that patients most likely to meet the criteria for catatonia are those experiencing an acute psychiatric illness and those with autism and other forms of developmental delays.

3) What is the role of benzodiazepines? What type, at what dose for how long?

Benzodiazepines are highly effective in the treatment of the psychomotor retarded subtype of catatonia (also known as the akinetic subtype), but are somewhat less effective in the agitated/excited subtype. However, for both subtypes, the first line pharmacological treatment is a benzodiazepine, usually lorazepam, which is inexpensive and readily available in oral, IV and IM formulations. If efficacious, the benzodiazepine should generally be continued over many months following the complete remission of catatonic symptoms. The therapeutic response to benzodiazepines is possibly via GABA-A receptors in the sensorimotor cortex which appear to be reduced. This reduction of GABA-A receptors is considered the underlying pathophysiological mechanism of the disorder (Northoff et al. 1999); indeed, catatonia is a GABA-mediated condition. Lorazepam is typically administered 3-5 times daily, often starting at 0.5-1mg TID and the increasing in an escalating fashion by 0.5mg TID every few days. Positive outcome is a reduction in catatonic symptoms, while a relative tolerance to the common sedative effects of this agent are rarely seen. Side effects may include excessive sedation, paradoxical excitement, unsteady gait or hypotension. The link below includes video recordings of a young man diagnosed with autism and agitated catatonia who was treated successfully with lorazepam; pre treatment and post-treatment videos demonstrate the positive effect noted in this case (informed consent was obtained from the parents). The response in the videos was noted over several months. The patient continues to receive this agent at approximately 15 mg/day.

Pre-treatment presentation of agitated catatonia: https://youtu.be/7jXkmY1pg3s

Post-treatment presentation of agitated catatonia: https://youtu.be/J LarsiEJGyA

4) When do you decide ECT is necessary?

Electroconvulsive therapy (ECT) is considered for any patient who has severe, life-threatening or life-limiting symptoms, fails to achieve his/her baseline and/or meets criteria for risk to self and/or others. These patients may have inadequate fluid or food intake, unable to function at their baseline level, engage in repetitive and high frequency self-injurious behaviors, or are severely agitated with/without features of malignant catatonia. Since malignant catatonia is associated with 10-20% mortality rates, ECT should be prioritized in these cases, where it can be truly life-saving.

5) What is the likelihood of recurrence?

Catatonia can be a recurrent condition and may also persist as a chronic condition over months or years. The exact frequency of recurrence or chronicity is unknown, however, the idiopathic and the affective subtypes may be more likely to recur (Barnes et al. 1986). In patients with a recurring or a chronic type of the illness, long term administration of a benzodiazepine and/or ECT should be considered. Preliminary experience suggests that patients with catatonia in the context of ASDs tend towards chronicity of the condition, requiring ongoing maintenance benzodiazepine and/or ECT therapies. This may be related to the static substrate of the autistic brain, including the baseline GABA-glutamate imbalance known to occur from fetal stages onwards, as compared to a more episodic affective, psychotic or medical condition associated with catatonia in an otherwise typically developing/developed brain.

References


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Mortal Kombat 11: Evaluating Violent Video Game Use Among Youth

Matthew Fadus, MD, and Atilla Ceranoglu, MD

On April 23, 2019, NetherRealm Studios will release its eleventh installment of the iconic video game series Mortal Kombat, seeking to push the previously unprecedented boundaries of violence and gore which have made the series immensely popular. Mortal Kombat allows gamers to control a character with a primary goal of brutalizing their opponent in a gruesome fight to the death. The series has claimed notoriety as one of the most violent video games to date, and has ultimately been defined by the fatality: a brief but dramatic visualization of one character dismembering, eviscerating, or decapitating their opponent in a theatrical, multi-step (and now slow-motion) fashion. Prior to Mortal Kombat’s initial release in 1992, the characteristic gore, dismemberment, and violence that was so prevalent in the game was largely unheard of among other video games.

As a result of the rising popularity of Mortal Kombat among impressionable youth, there was a growing sentiment that video game violence was “training early killers,” leading to a 1993 U.S. congressional hearing led by Democratic Senators Joseph Lieberman and Herb Kohl which sought to denounce video game violence and its potential corrupting influence. These efforts eventually led to the creation of the Entertainment Software Rating Board in 1994, a self-regulatory body of major video game developers and publishers which established rating systems for video games. Mortal Kombat was the first high-profile game to receive a “Mature” rating, which restricted anyone under the age of 17 from purchasing it without the consent of a parent or guardian.

Now almost 30 years later, Mortal Kombat 11 will launch in April 2019, seeking to be the most violent release of the series yet. The game will likely provoke further debate regarding the influence of video games on aggressive and violent behavior among youth, as video game violence has been a point of contention for decades among scientists, politicians, and clinicians.

The debate has lead researchers to seek answers regarding a causal link between violent video game exposure and aggressive actions of violence. For example, after the release of Mortal Kombat 1 and 2, a 1996 study found that hostility was increased after just 10 minutes of playing the game, an inference made as a result of participant responses from hostility questionnaires. The study concluded that the level of violence in the game should be of concern to consumers. Studying the association between video game violence and subsequent aggressive behavior is difficult. Outcome measures in laboratory research are not real-world physical acts of aggression as a result of ethical constraints, making laboratory-based measures difficult to generalize. Outcomes instead are measures of aggressive thoughts or language, or other non-serious measures of aggression. As a result, these unstandardized and less significant measures of aggression tend to inflate the effects of causality.

However these experimental methodologies have been scrutinized by some experts, as studies often use poorly validated outcome measures of real-world aggression, or have failed to control for other variables such as family violence, genetics, psychopathology, and developmental age and stage of the youth who play these violent video games. Some experts suggest that many of these studies have ignored other and more significant predictors of violent behavior in youth.

 Critics have also indicated that publication bias may overestimate causality. Publication bias occurs when studies with statistically significant effects, no matter how small of a practical effect, are more likely to be published than those with null results. This means that studies which do not find any suggestion of causality between violent video game exposure and aggression may have more

continued on page 172
difficulty being published. Publication bias commonly occurs among topics that are intensely debated in the research field, which video game violence has been over last the few decades.

However, more and more research has emerged, and recent studies have suggested that violent video games increase aggressive thoughts and behaviors, decrease empathy, and desensitize youth to violence. \(^1\)\(^-\)\(^5\) Although violent video games have been associated with non-violent delinquent behaviors such as cheating, skipping school, stealing, and substance use, few studies found a link between violent video game exposure and overt physical aggression until a recent article was published. The researchers in this study designed a meta-analysis to mitigate the aforementioned methodological concerns, and analyzed a total of 24 studies with over 17,000 participants. \(^5\) The study examined outcome measures of overt physical aggression (rather than just aggressive thoughts or statements), while controlling for confounding variables such as age and baseline aggressive behavior. Findings included a small but statistically significant correlation between video game violence and aggression. \(^5\)

However, critics question if there are any significant real-world effects of these findings, and studies as recent as 2019 report conflicting evidence. \(^6\) It is likely that the April 2019 release of Mortal Kombat 11 will again spark discussion and intensify the debate regarding video game violence, and may even contribute to the lofty rhetoric implying causation to mass-shooting behaviors. While debate goes on as to whether video games increase violence or aggression in players, it runs the risk of overshadowing more valid and real concerns associated with the circumstances of video game play on youth. Lack of supervision of video game play may lead to or confound problems with sleep, academics, attention problems, depression, and anxiety, which must be carefully considered among the established benefits of gameplay. Video games deserve a critical examination of their effects in real-world settings, particularly related to aggressive behaviors and violence. There are valid concerns about the excessive violence seen in Mortal Kombat 11 and many other video games; however, demonizing violent video games and limiting their use altogether among youth would be misguided and premature.

References


I Left My Heart at the Border

Shawn S. Sidhu, MD, FAPA, DFAACAP

The drive out to Cibola Detention Center by Grants, NM, has become quite familiar. My trusty old 2008 Honda Accord has logged 2600 miles back and forth over the past year and half. At first I noticed common landmarks, such as the Route 66 Casino, signs for the world famous Laguna Burger, or the Acoma Sky City Casino. Nowadays I count outcroppings of red and limestone rock, vast desert valleys, and the curves of Interstate-40 itself as my companions.

Even those living New Mexico may not know that the Cibola County Detention Center, a for-profit private prison run by Core Civic, is also home to an ultra-specialized U.S. Immigration and Customs Enforcement (ICE) unit for transgender women. These women presented to the border and requested asylum, reporting torture and persecution in their home countries on the basis of their gender. If they pass an initial screening by a U.S. Customs and Border Patrol Officer and another Credible Fear Interview by an Immigration Officer, they are then transferred to Cibola County Detention Center to await a hearing with a federal immigration judge.

I’ve always found the physical appearance of Cibola County Detention Center to be quite the paradox. Idyllic sunny blue “big sky country” skies, billowing white clouds, and picturesque desert mesas surround what is unmistakably a federal prison. Inmates wearing distinct orange jumpsuits can be seen walking laps or playing pickup games of soccer behind towering barbed wire fences. Buses full of new inmates periodically creep up to the checkpoint and then proceed behind the metal gates. Visitors must proceed to the entrance point and go through a metal detector while their belongings are scanned along a conveyor belt. Electronics, such as cell phones or computers, are not permitted inside the facility. After being cleared I am then lead to the ICE portion of the prison by an ICE officer. Over the past year or so I have become friendly with many of the ICE officers at the facility. I have inquired about their families and why they chose to work at the facility. They, in turn, have gone out of their way to accommodate my requests to interview clients. The harsh reality is that apart from Cibola County Detention Center, gas stations, and a few casinos, there is little to no meaningful employment in rural New Mexico. While for-profit prisons are highly controversial for many reasons, in Grants, NM, it can be hard to find other jobs that pay well enough to put food on the proverbial table.

As a child and adolescent psychiatrist my role is to provide a pro-bono mental health evaluations for the transgender women who are seeking asylum from within the facility. I spend a few hours interviewing the women, and then write a comprehensive forensic report that attorneys use in their case. My life has been changed by the stories I have heard from the transgender women at Cibola. Child and adolescent psychiatrists, especially those practicing in New Mexico, are quite familiar with even the most severe forms of trauma, abuse, and neglect. Yet, nothing in my training or career to date could have prepared me for the stories I was about to hear from these women. Each woman with whom I met reported unspeakable atrocities, persecution, and torture on the basis of being transgender. This includes exploitation, kidnapping, and sex trafficking by gangs, police, and military personnel with little to no protection under the law of their respective countries. Some even reported electrocution. The vast majority of women whom I interviewed, if not all of them, appeared to be answering these questions honestly, and often fell apart emotionally when telling me about their tragic journeys. Many looked me in the eyes and were blunt about the fact that they would be murdered if they returned to their country of origin.

Despite undergoing unspeakable atrocities, I have been humbled and inspired by the fact that most of these women have found a way to keep going. They support one another emotionally and find a way to remain hopeful. For many, the American dream represents the freedom to live in their own skin, and identified gender, without having to fear torture, persecution, and exploitation. Physicians seldom get the chance to participate in freeing someone from the bonds of torture and persecution. Most of us derive satisfaction from symptom resolution in our patients. The sheer exhilaration I feel when I find out one of the Cibola women has been granted asylum is unmatched in the other areas of my work, and it is what has kept me going back all this time. Interstate-40, I’ll be seeing you again sometime soon my dear old friend.

Shawn S. Sidhu, MD, Albuquerque, New Mexico, shawnsidhu@gmail.com.

In 1885, Chicago became home to the first skyscraper, the Home Insurance Building, which was originally nine stories tall.
M. H. Kiser

As child and adolescent psychiatrist, we gather various types of information from our patients. To perform a comprehensive assessment, we strive to understand their histories, come up with an accurate diagnosis, and develop a treatment plan to relieve their symptoms and improve their functioning. To elicit that information, we often have neither the time nor the opportunity to hear our patients’ narratives: how they see themselves, conceptualize their illness, how their illness impacts their daily life, and experiences of interactions with our profession. Of course, these factors are critically important. For many of us, fascination with people’s stories and curiosity about their lives drew us to this subspecialty. Narratives can help us develop a deeper understanding of our patients’ concerns and strengths and may lead to finding that illusive hook with a resistant teen. To give our members that important perspective, we are sharing this essay by a teenager who describes his experiences with obsessive-compulsive disorder (OCD).

Cathryn A. Galanter, MD
Co-Chair, Consumer Issues Committee

I like to think of myself as an expert in the hand-washing department: I’m efficient, and I do it a lot, like a lot. I wash my hands even when I don’t need to wash them. I wash my hands when I get close to something nasty. I wash my hands even when I just think about falling in the boys’ bathroom. Yeah, you guessed it, I have OCD.

For me, using any form of public restroom requires strategy and skill. I must scope out my surroundings and work out a plan. 1. Open the bathroom stall with one hand. 2. Kick the stall door back open. 3. Wash hands and turn the faucet off with paper towel. 4. Exit without touching the door. And this is just the beginning of what I face every single day.

I was never a good liar, thanks to my OCD, but in seventh grade, my honesty was far from normal for a typical teen. Telling your mother everything about your life (especially after hitting puberty) can be humiliating. These confessions I made, and still make are usually because of an irrational thought that OCD makes me obsess and feel guilty about. For example, “Hi mom, I think I’m a sexual predator, you are perfectly justified to call child services now.” Thoughts like these would, and still do, beat me down and can consume me some days. It started out with just worrying that I was a pervert, but as time passed, more topics arose, covering many aspects of life. Am I a racist? Am I a sexist? Am I a terrorist? Am I ungrateful to my family? Along with many other irrational thoughts. You could say that sometimes I feel guilty for just being alive.

But OCD mostly just causes me to focus on something too much. Like on a drive back from the beach in Maine. Something was not right. Something was off. My ear was clogged. I tugged at my lobe. Nothing. I tugged again. Over, and over, and over. Suddenly air rushed through my ear and sound came flowing with it. A wave of relief crossed over me. But soon it clogged again and anxiety again rushed over me. I tugged at my earlobe and nothing happened. I tugged and tugged and tugged but nothing happened. A feeling of panic washed over me. I felt trapped. Over and over I devised new strategies to unclog my ear, and it soon became another obsession. My ears were always clogging, and I was always tugging and clawing and sticking pencils inside it. I could not be happy when my ear was clogged.

People think that having OCD is just washing your hands a lot and fixing stuff up. In reality OCD is more like having another person inside of your head, telling you what to think, what to feel, what to do. I am really three people. I am me on the outside, OCD in the middle, and very deep inside, is the real me.

However, OCD can also make me insistent and determined sometimes, and that can be a good thing. Once I had a long obsession with tumbling. I learned how to do all sorts of tricks from YouTube. I started practicing no-handed cartwheels. I imagined myself proudly doing an aerial in the park. I practiced all the time, even on rainy miserable days. Even in our small bedroom upstairs (my parents said it sounded like I was renovating the house because of all the crashing noises!!!). Finally, I did it while I was practicing at our grandparent’s cottage. I felt myself fly through the air, my feet landing hard on the dirt road. I was shocked and elated. All my practice had come to fruition. Without OCD and the hours I had practiced, I would not have been able to achieve that.

My OCD will never go away, I will have it forever. It is part of who I am. But that doesn’t mean it has to own me forever. I have been working hard to recognize the voice and shut it out. A part of my day is still fighting OCD. Sometimes I have bad days and I spend hours and hours fighting OCD, but that’s okay, because if it was a person, I would have one thing to say to it, “F you.”

If you have essays written by children, adolescents, or parents about their experiences with their mental health and their experiences with child and adolescent psychiatry that you think will be helpful for our members, please consider submitting them to AACAP News. As with all submissions, they will be reviewed for consideration by the AACAP News Editorial Board.
ABPN Launches Pilot Alternative to Ten-Year MOC Examination

Christopher R. Thomas, MD

The ABPN administered its first recertification examination in 2000 in the subspecialty of geriatric psychiatry, and it was an open book, take home exam. Subsequently, the American Board of Medical Specialties (ABMS) specified that all Maintenance of Certification (MOC) Part III examinations be administered under proctored, closed book test conditions. As the Boards gained more experience, other options such as modular MOC examinations and multiple examinations during a MOC cycle were proposed. In 2015, the ABMS revised the MOC standards to encourage Member Boards to explore new methods of evaluating diplomate knowledge. While the ABPN had been continuously reviewing its MOC program, a more intensive consideration of its MOC Part III requirement was undertaken. The purpose of this article is to outline the deliberations that began in 2016 and led to the January 2019 launch of a Pilot Project for a new format consisting of short, on-line tests based on selected journal articles.

In Spring 2016, the ABPN held a Crucial Issues Forum on MOC with attendees from major stakeholder organizations, including the American Psychiatric Association (APA) and the American Academy of Neurology (AAN) as well as other professional societies. At this meeting, alternatives to the MOC Part III examinations were discussed. Representatives of the American Board of Medical Specialties (ABMS), Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), and Accreditation Council for Continuing Medical Education (ACCME) provided their organizations’ perspectives; representatives of the American Boards of Emergency Medicine, Internal Medicine, and Obstetrics and Gynecology reviewed their plans for MOC Part III. Options were discussed in small groups, and the feedback was recorded for future consideration. The ABPN also appointed a MOC Clinical Advisory Committee made up of members who were in practice to provide additional perspectives on recertification.

After careful deliberation, the ABPN Directors concluded that a format that would best serve the ABPN’s diplomates should have the following characteristics:

- Contribute to lifelong learning
- Be relevant to clinical practice
- Allow for some tailoring based on professional interests
- Be available more frequently than current ten-year examinations
- Take place in the least restrictive testing environment possible
- Yield informative feedback

Hence, in July 2017, the ABPN Directors approved a Pilot Project based on journal articles that consisted of short, on-line, open book examinations for Part III MOC in psychiatry, neurology, child neurology, and child and adolescent psychiatry. In Fall 2017, the Pilot Project was approved by the ABMS Committee on Continuing Certification. The following parameters were established for the three-year Pilot Project:

- To assure that a broad range of topics are covered, content outlines were developed based on the current MOC examination outlines. As shown in Table 1, each has 10 categories, with the goal of identifying 4 articles per category for a total of 40 articles.
- All selected articles must have direct clinical application and usually should have been published in the past five years in peer-reviewed journals listed on Medline. Practice guidelines and other important clinical references are also acceptable.
- Five multiple-choice questions were developed for each article and include at least one question about a specific and meaningful detail, one conclusion question that can only be answered by reading the entire article, and at least two questions focused on the clinical application of information contained in the article.
- To get credit for an article, the diplomate must answer at least four of the five items correctly on the first attempt.
- To pass the Pilot Project, diplomates must earn credit for 30 articles.

“To be honest, I expected to prefer this slightly more than the exam, but I didn’t expect to be this enthusiastic. I thought the articles were well chosen and I have already applied some of what I learned to my practice. I was happy to have a bunch of pertinent articles curated for me and I thought that the majority were extremely interesting.”

MOC Pilot Test Committees with 11 members each were established for each examination. The ABPN nominated five members for each committee and selected the remaining six from nominations made by the related professional organization (i.e., APA, ANA, the Child Neurology Society, and the American Academy of Child and Adolescent Psychiatry). The committees began selecting articles in Spring 2018.

continued on page 176
and wrote and edited questions over the summer. Two committee members selected articles for each outline category. The final article was selected based on the whole committee’s review and approval.

In Fall 2018, the test administration platform was selected, and alpha testing of the on-line examinations was carried out by MOC Pilot Test Committee members and the ABPN Directors. The paramount concerns were ease of using the interface, speed and interpretability of test results, and data security. The test included feedback surveys on each article, the test questions, the test delivery platform, and the Pilot Project as a whole. The Project’s staff and committee chairs monitored responses and comments on test questions in the same fashion as for other ABPN examinations, and items were rescored and revised if appropriate.

Announcements on the ABPN website, newsletters, and emails informed eligible diplomates due for recertification in 2019-2021 about the MOC Pilot Project. There is neither extra cost for diplomate
participation nor any penalty if a diplomate chooses to drop out or fails to complete the examinations, although they will have to take a proctored recertification examination. Thus far, the response has been enthusiastic, with 64% of the eligible diplomates (~16,000) agreeing to participate. Of those, about 4,600 have already completed one or more of the examinations; comments have been very positive. For example, a diplomate wrote, “To be honest, I expected to prefer this slightly more than the exam, but I didn’t expect to be this enthusiastic. I thought the articles were well chosen and I have already applied some of what I learned to my practice. I was happy to have a bunch of pertinent articles curated for me and I thought that the majority were extremely interesting.”

The Pilot Project will run from 2019-2021, and the overall success will be measured by:

- Proportion of eligible diplomates who volunteer to participate
- Proportion of diplomates who complete the pilot
- The diplomates’ rate of success
- Diplomates’ overall satisfaction on the exit surveys
- Relevance and quality of the selected journal articles as indicated by the examination surveys
- Total test scores for each article and performance variation across articles
- Quality of the test questions as assessed by item statistics, number of corrected items, and examination surveys
- Test delivery problems and user satisfaction with the delivery platform
- Feedback from professional societies

At the end of the Pilot Project, the ABPN will analyze the data and, if appropriate, request that the ABMS approve the new format as a permanent replacement for the current MOC Part III examinations.

The goal of MOC requirements is to document the continued growth and performance of certified clinicians. The ABPN Pilot Project guides the continued learning with at-home examinations on peer-selected articles that address important clinical issues. This format fits more easily than traditional tests into busy schedules, and when important issues arise for clinicians, such as the opioid crisis, they can be addressed more quickly than in the current ten-year examination cycle. The Pilot Project exemplifies the ABPN’s commitment to serving psychiatry and neurology by promoting excellence in practice.

Christopher R. Thomas, MD, Robert L. Stubblefield Professor, UTMB/Department of Psychiatry, cthomas@utmb.edu.

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**Did You Know?**

The longest MLB game to ever be played was in 1984 at Comiskey Park in Chicago. The Chicago White Sox defeated the Milwaukee Brewers after 25 innings.

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**Participating the ABPN MOC Part III Pilot Project?**

Your AACAP membership grants you FREE access to 29 of the 40 articles selected for the Pilot Project. To find a complete list of all articles, including links to each, please visit www.aacap.org/pilotproject.

For questions regarding the Pilot Project please contact the ABPN at 847.229.6500.


For all other questions please contact cme@aacap.org or 202.966.7300, ext. 2007.
**HIPAA Business Associate Agreement: What is It and Do I Need One?**

Moira Wertheimer, Esq., RN, CPHRM, FASHRM, Vice President, Risk Management Group

The HIPAA Privacy Rule (HIPAA) applies to Covered Entities (CEs), which include healthcare providers who transmit any protected health information (PHI) in an electronic form. HIPAA permits CEs to employ a Business Associate (BA) to help carry out its health care activities and functions. Specifically, a BA is person/entity who is engaged to do work involving the use/disclosure of PHI on behalf of a CE. In a physician practice, BA activities often include: billing, claims processing, legal services, accounting services, e-prescribing, medical transcription services, etc. The CE’s staff members are not considered BAs under HIPAA, they are considered part of the workforce.¹

When employing a BA, HIPAA requires the CE to obtain satisfactory assurances in writing that the BA will safeguard the PHI it creates or receives on behalf of the CE. These written assurances the BA gives to the CE are referred to as Business Associate Agreements (BAAs).

HIPAA specifically identifies the elements needing to be included in the BAA.² Among other things, the BAA must:

- Require the BA to safeguard the PHI from unauthorized uses/disclosures
- Require the BA to report to the CE any unauthorized use/disclosure of PHI including incidents that constitute breaches of unsecured protected health information
- Require the BA to disclose PHI as specified in its contract to satisfy a CE’s obligation with respect to individuals’ requests for copies of their PHI
- Require the BA to comply with the HIPAA requirements applicable to carrying out their contractual obligation on behalf of the CE
- Require the BA to make available to HHS its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the BA on behalf of, the CE for purposes of HHS determining the CEs compliance with the HIPAA Privacy Rule;
- Require the BA at termination of the contract, to return or destroy all PHI received from, or created or received by the BA on behalf of, the CE
- Require the BA to ensure that any subcontractors it may employ on its behalf that will have access to PHI agree to the same restrictions and conditions that apply to the BA
- Authorize termination of the contract by the CE if the BA violates a material term of the contract.

Note that contracts between BAs and their subcontractors are also subject to these same requirements. A sample BAA can be found at the U.S. Department of Health & Human Services: [http://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html](http://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html). As always, it is prudent to consult with your attorney prior to entering into any contracts to ensure compliance with applicable federal/state laws.

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**References**

1 45 CFR 160.103 (Definition of Business Associate)
2 45 CFR 164.504(e)

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Chicago is home to many inventions, such as, the zipper (1851), vacuum cleaner (1868), dishwasher (1886), 16-inch softball (1887), the Ferris wheel (1893), the Twinkie (1930), deep-dish pizza (1943), spray paint (1949), and wireless remote control (1955).
Lifelong Learning Modules

Earn one year’s worth of both **CME and self-assessment credit** from one ABPN-approved source. Learn from approximately 35 journal articles, chosen by the Lifelong Learning Committee, on important topics and the latest research.

Visit [www.aacap.org/moc/modules](http://www.aacap.org/moc/modules) to find out more about availability, credits, and pricing.

Improvement in Medical Practice Tools

*(FREE and available to members only)*

AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved **checklists and surveys** to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish. AACAP members can download these tools at [www.aacap.org/pip](http://www.aacap.org/pip).

Live Meetings

([www.aacap.org/cme](http://www.aacap.org/cme))

**Pediatric Psychopharmacology Institute**
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**Questions?**
Contact us at cme@aacap.org.

[www.aacap.org/moc](http://www.aacap.org/moc)
AACAP’s 2019 Legislative Conference Wrap-Up

Over 200 child and adolescent psychiatrists, residents, medical school students, and family advocates descended on Washington, DC, May 2-3, during AACAP’s Legislative Conference to advocate on behalf of child and adolescent psychiatry and the patients AACAP members serve. The Legislative Conference, hosted by the American Association of Child and Adolescent Psychiatry, the 501(c)(6) arm of AACAP, is its annual premier advocacy event.

Attendees were briefed on and given materials needed to advocate for three priority policy issues including: student loan relief for mental health professionals, including child and adolescent psychiatrists; improving mental health in schools; and, keeping migrant families together.

Attendees promoted the Mental Health Professionals Workforce Shortage Loan Relief Act of 2019, sponsored by Reps. John Katko (R-NY) and Grace Napolitano (D-CA), and Senator Kamala Harris (D-CA). This bill aims to increase the child and adolescent psychiatry workforce by paying 1/6 of eligible medical student loan debt in exchange for each year working in a mental health professional shortage area for up to six years.

The Mental Health Service for Students Act, H.R. 1109 or S. 1122, sponsored by Reps. Napolitano, Katko, and Senator Tina Smith (D-MN) was the second priority issue of the conference. This legislation would boost mental health services in K-12 schools by expanding a competitive grant program administered by the Substance Abuse and Mental Health Services Administration.

A new priority at AACAP’s Legislative Conference was the importance of promoting family unity for migrant children by supporting the American Dream and Promise Act of 2019, H.R. 6, or the Dream Act, S. 874.

All told, 180 Congressional meetings were scheduled on behalf of conference attendees who fanned out across Capitol Hill on behalf of AACAP and our priority legislative agenda after rigorous training by members of AACAP’s Advocacy Committee and the Government Affairs Department.

During the legislative training, Avanti Bergquist, MD, an elected member of her local school board and spouse to Washington State Representative Steve Bergquist, spoke from personal experience about the ways in which meetings with elected officials could steer off topic, or become unfocused. She reassured attendees it was acceptable to not immediately know all the answers to staff questions and helped allay fears by providing techniques which attendees could implement to ensure a successful meeting and build ongoing relationships with Members and staff.

Laura Willing, MD, a former AACAP Resident Scholar and Legislative Fellow in the office of Senator Chris Murphy (D-CT), detailed her experience working as a child and adolescent psychiatrist on Capitol Hill, her role in passing mental health reform legislation, and provided first-hand knowledge of what to expect when entering the halls of Congress.

Director of Government Affairs and Clinical Practice, Ronald Szabat, Esq., alongside Michael Linskey, Deputy Director of Congressional and Political Affairs, helped to lead the two-day legislative training with the active involvement of many members of AACAP’s Advocacy Committee, including committee co-chairs, Debra E. Koss, MD, and Karen Pierce, MD.

AACAP awarded its Friend of Children’s Mental Health award to two Congressional champions of children’s mental health, Senator Tina Smith, sponsor of the Mental Health Services for Students Act, and Representative Anna Eshoo (D-CA), chair of the U.S. House Committee on Energy and Commerce Subcommittee on Health.

In continuing the tradition, residents again applied for and were awarded grants through the Advocacy Fellow Ambassador Program. This opportunity provides a travel stipend to offset the cost to attend the conference to a limited number of residents who must also secure a matching grant from his or her regional organization of child and adolescent psychiatry. These awards are offered on a first-come, first-served basis, and are a way in which regional organizations may recruit and build the advocacy workforce of their state.

AACAP recruited numerous family advocates from states across the country, some of whom have given their time to attend the Legislative Conference for 10 years in a row, indicating the power of a patient perspective when meeting with Congressional staff and members of Congress. Roy Ulrickson, family advocate from Maine, addressed attendees about what it meant to him and his son Thomas, also in attendance, to join AACAP members during the Legislative Conference. AACAP members are encouraged to recruit possible family advocates who may be interested in sharing their stories related to children’s mental health and willing to travel to Washington, DC, for the 2020 Legislative Conference. Upon application and approval, AACAP covers the costs for family advocates to attend the conference.

New this year, two members of AACAP’s Advocacy Committee, Pamela Hofman, MD, and Adam Sagot, DO, promoted ways in which conference attendees could amplify their voice as well as the legislative priorities of the conference by using social media and #AACAPLC19 in Twitter posts during the conference.

AACAP will host the 2020 Legislative Conference in Washington, DC, on April 2-3, which will again occur prior to the Spring AACAP Assembly meeting on April 4. Please plan now to join us!
My First Legislative Conference

Karen Lai, MD

I approached my very first AACAP Legislative Conference in Washington, DC, with both excitement and trepidation. Excitement, because this would be a new experience for me, and yet I wanted to learn more about how to advocate for issues I am passionate about, including expanding access to mental health services nationwide, whether at schools or through building a more comprehensive child and adolescent psychiatry workforce. Trepidation, because I had no idea how members of Congress, and their staff, would react to my hastily devised “elevator pitch” describing my requests. Would they be more knowledgeable than I about these issues, or ask me tough questions I would struggle to answer?

I needn’t have worried. AACAP was well prepared for newbies like me. AACAP staff from the Government Affairs department, ran a “how-to” workshop that helped me feel much more confident about approaching my Senators’ and Representatives’ offices the next day. I received a full packet of information about the three bills, and relevant facts supporting them, that we as AACAP members were hoping to push forward in our scheduled brief conversations with legislative staffers from our localities.

The first bill, H.R. 2431: “Mental Health Professionals Workforce Shortage Loan Relief Act of 2019” or “Ensuring Children’s Access to Specialty Care Act of 2019,” attempts to ameliorate the child and adolescent psychiatry workforce shortage across the nation via loan relief. The second, H.R. 1109 or S. 1122: “Mental Health Services for Students Act of 2019,” focuses on getting mental health services, including child psychiatry services, on-site to schools, where they will have the most impact on youth, who spend 1/3 of their day at school. And the last, S. 874: “Dream Act of 2019,” or H.R. 6: “American Dream and Promise Act of 2019,” would avoid harmful and traumatic separation of migrant children from their families. Each of these issues has impacted me in my life as a child psychiatrist, and I was glad to see that I would have a chance to speak up about my personal experiences and passions to my elected officials. I was also amazed to see that almost all of these bills have bipartisan support – the better to show just how non-partisan and important the topic of children’s mental health is, and to greatly increase the bills’ chances of success!

Over the course of the training, we learned about various ways to enhance our impact – such as using personal stories, drawing upon shocking but true statistics about children’s mental health, leveraging social media, and bringing a focused message. We were armed with colorful and effective graphics to show and provide at our meetings. Nevertheless, I was still a bit nervous until the moment I stepped into the office of Sen. Kamala Harris (D-CA) and experienced my first conversation with legislative staff. Across the board, I found that these legislative staffers were genuinely interested in what I had to say, asked good questions, and were open to our information and requests.

In the end, I came away from my first Legislative Conference experience with a lot of learning points. I learned, to a more in-depth extent, how the legislative advocacy process works on Capitol Hill. I learned why having an advocacy arm within AACAP is so important. Lastly, I learned that my voice and my stories are important, and people do really want to hear them! Knowing that, I feel energized to not only return to Legislative Conference next year, but also continue my advocacy efforts from home. As was emphasized during the conference, each of us can continue to work actively on local and national issues through one or all of the following:

- Participate in our regional organizations (ROCAPs);
- Write letters and make phone calls to our elected representatives on issues of interest; and
- Donate to the AACAP Political Action Committee (AACAP-PAC), a separate organization from the Academy, to continue promoting these issues on a national level.
LEGISLATIVE WRAP-UP
LEGISLATIVE WRAP-UP

JULY/AUGUST 2019
Check Out AACAP’s Newest Online CME Courses

Check out AACAP’s latest online CME course, Current Topics on Pediatric Psychopharmacology: An Online Advanced Course. This course, co-chaired by Barbara J. Coffey, MD, and Timothy E. Wilens, MD, includes clinically relevant, evidence-based pediatric psychopharmacology updates.

Course highlights include:
- Presentations by nine top child and adolescent clinicians from past AACAP Psychopharmacology Institutes
- Important topics such as autism spectrum disorder, attention-deficit hyperactivity disorder, pediatric bipolar disorder, and many more
- Up to 8 AMA PRA Category 1 Credits™ available

Clinical Essentials

Clinical Essentials on Depression, the second course in our new online CME series, is now available for purchase.

This course, created by child and adolescent psychiatrists with educational expertise, was designed for busy physicians looking to update and expand their knowledge on the most clinically relevant information on depression.

Course highlights include:
- Highly rated videos and lectures from past AACAP activities
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- Up to 6 AMA PRA Category 1 Credits™ available

To purchase one or both courses, please visit the AACAP store at www.aacap.org.

Questions? Contact the CME Department at 202.966.7300 ext. 2007 or cme@aacap.org.
Register for AACAP’s 66th Annual Meeting Starting in August!

Registration for the Annual Meeting will open on August 1 for AACAP members and August 8 for non-members. Be sure to register early to secure all of your preferred events. Register online at www.aacap.org/AnnualMeeting-2019.

Review the Extensive Programming Being Offered at the 66th Annual Meeting

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

Promote Your Book at This Year’s Annual Meeting!

Join us at our “Meet the Author” booth in the Exhibit Hall. Sign up for a one-hour time slot to promote your book. We include a 50-word description on a flyer distributed to all attendees as well as a listing in the Annual Meeting Program Book. Limited time slots are available beginning on Wednesday, October 16 through Friday, October 18.

Pricing: $300 per hour*

*Descriptions received by August 20, 2019 will be published in the Annual Meeting Program Book and special event flyer. Requests received after August 20 are not guaranteed to appear in printed promotional material.

Be the first author to sign up!

More information can be found at: www.aacap.org/exhibits-2019

Questions? Please contact meetings@aacap.org.
AACAP’s 66th Annual Meeting

Chicago Preview

AACAP’s 66th Annual Meeting is just 2 months away and we’re excited! Whether you’re bringing the family, laser-focused on our high-quality programs, or somewhere in between, we have scoped out the best that our destination has to offer, and have highlighted important information here. For complete details about the Annual Meeting, visit www.aacap.org/AnnualMeeting-2019.

Attendee To-Do List

- **August 1** – Members only registration opens
- **August 8** – Registration opens to nonmembers
- **September 12** – Early bird registration deadline
- **September 20** – Last day AACAP room rate guaranteed at hotels
- **September 23** – Last day to register online
- **October 14** – First day of AACAP’s 66th Annual Meeting
- **October 19** – Last day of AACAP’s 66th Annual Meeting

**HOTELS**

Hotel rooms in Chicago are selling quickly! Please visit the hotel page of the Annual Meeting website for more details and information.

<table>
<thead>
<tr>
<th>Hotel Name</th>
<th>Address</th>
<th>Phone</th>
<th>Reservations Phone</th>
<th>Rate</th>
<th>Check-in/Check-out</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hyatt Regency Chicago</strong></td>
<td>151 East Wacker Drive</td>
<td>312.565.1234</td>
<td>312.565.1234 Ext. 4419</td>
<td>$276 single/double per night</td>
<td>3:00 pm/12:00 pm</td>
</tr>
<tr>
<td><strong>Radisson Blu Aqua Hotel</strong></td>
<td>221 North Columbus.</td>
<td>312.565.5258</td>
<td>800.333.3333</td>
<td>$260 single/double per night</td>
<td>3:00 pm/12:00 pm</td>
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When making your reservation, ask for the AACAP ANNUAL MEETING GROUP RATE to qualify for the reduced rate.

Situated in the heart of bustling downtown Chicago, both hotels are optimal options to explore the Windy City.

**TRAVEL**

**Plane**

The two main airports in Chicago are O’Hare Airport (ORD) and Midway Int. Airport (MDW). The transit time from Central Loop to O’Hare International airport or Midway International Airport is approximately 40 minutes. For more information about the airlines serving these airports, flight schedules, and ground transportation options, visit http://www.flychicago.com.

**Train**

Amtrak serves Chicago with about 50 trains arriving and departing daily at Chicago Union Station. For more information and to book tickets, please visit: https://www.amtrak.com/stations/chi.
AACAP Staff Picks for Chicago

Trying to decide how to make the best of your experience in the Windy City? Let the AACAP staff guide your way around the city! Check out the top 10 attractions picked by AACAP staff as well as other recommended activities and bucket list items!

AACAP STAFF’S TOP TEN CHICAGO ATTRACTIONS

1. Art Institute of Chicago
2. The Second City
3. Museum of Science and Industry
4. Chicago Children’s Museum
5. The Field Museum
6. Wrigley Field
7. Adler Planetarium
8. Chicago Riverwalk
9. Millennium Park
10. Navy Pier

AACAP STAFF-RECOMMENDED ACTIVITIES

- The river architecture tour, via boat, is AMAZING!!!! (Michael)
- Green Mill Cocktail Lounge for jazz (Shoshana)
- Oak Street Beach located north of the Drake Hotel (Ron)
- Imperial LaMian is a wonderful restaurant to which I plan to return (Karen)
- Whirlaway Lounge – one of the best Dive Bars in the city! (Rob)
- The daily homemade chicken soup at the Hyatt Regency Chicago is amazing. (Jeffrey)

AACAP STAFF’S CHICAGO BUCKET LIST

We also asked the AACAP Staff what they’re looking forward to doing or visiting in Chicago. Here’s what they had to say:

- I very much want to visit/stay at the Chicago Athletic Association Hotel. It was built in 1893 and is super cool. My husband mentioned that you can go on boat tours to view the Chicago architecture. (Kristine)
- Gino’s East and Chicago Pizza and Oven Grinder Co (Rob)
- Buckingham Fountain in Grant Park (Mary)
Helen Beiser, MD, Art Show

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

Coordinated through AACAP’s Local Arrangements Committee and Art Committee, we invite creative AACAP members and their family to submit artwork to make this year’s show spectacular! You may exhibit up to three pieces of art. We are looking for original works including paintings, drawings, illustrations, potteries, sculptures, calligraphy, poetry, letterpress broadsides, artist’s books, and photographs. The Art Show, open October 16-18, is for exhibition purposes only—no pieces are offered for sale.

Also, all artists are welcomed and encouraged to participate in “Meet the Artists” in the Exhibit Hall (date and time TBD). This event will give you the chance to showcase your art first-hand to the Annual Meeting attendees. Don’t miss out on this exciting opportunity!

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

To submit an artwork application, please register and submit artwork online at https://aacap.wufoo.com/forms/rpgnjpn0k4pehc/.

AACAP members who refer a new Annual Meeting exhibitor will receive a $100 discount off their 66th Annual Meeting registration. Referrals apply to first-time AACAP exhibitors who purchase a booth for AACAP’s 66th Annual Meeting in Chicago.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals, as well as advertise in several of the Annual Meeting publications. Historically, AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. To review the Invitation to Exhibit with more details on this opportunity, visit www.aacap.org/exhibits-2019.

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

Show your support for AACAP and SAVE today!
Medical Students, Residents, and Trainees: Attend AACAP’s Annual Meeting for FREE!

Register as a Monitor and we’ll waive your general registration fee!

AACAP’s Annual Meeting is the largest gathering of child and adolescent psychiatrists in the world. Monitors assist AACAP staff in running the meeting by checking badges, collecting tickets, assisting speakers as needed, and coordinating evaluation forms. Monitors are expected to commit to one full-day or two half-day sessions at the Annual Meeting.

**Why Become a Monitor?**
- FREE general registration for all Monitors.
- Half-priced tickets for most ticketed events.
- Six days of scientific content presented by top experts in the field.
- Customized programming, including mentorship programs.
- Networking opportunities with presenters and peers.

**Members Benefit Even More!**
- Monitor registration opens August 1 for AACAP members only. Nonmember registration opens August 8.
- All Monitors choose their own assignments through the registration system. Increase your chances of getting the Monitor assignment that you want by becoming an AACAP member today!

For more information about the Monitor Program visit [www.aacap.org/AnnualMeeting-2019](http://www.aacap.org/AnnualMeeting-2019) or email [meetings@aacap.org](mailto:meetings@aacap.org)
The Wicked Problem of Transitional Care for Youth with Autism

“We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right—one after the other, no slipups, no goofs, everyone pitching in.”

Acclaimed writer, surgeon and public health researcher Atul Gawande alludes to this wicked problem concept in medicine, “We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right—one after the other, no slipups, no goofs, everyone pitching in.”

Ironically, youth and young adults with autism are the very people who are in exceptional need of continuous, comprehensive health care. Financially, this population’s hospital visits contribute to greater medical expenditures, which could be curbed by smoother care-coordinated transitions. Yet, just last year, Kast et al. (2018) published in the premier journal Pediatrics, that only 21% of youth with autism receive health care transition services, well below the rates of their peers and others with special healthcare needs. So why isn’t this glaring problem being addressed? What will it take to solve? Recall Gawande’s words.

Now, let us recall that the definition of autism spectrum disorder ranges from barely perceptible symptoms to nonverbal with frightening behaviors, often related to difficulty communicating. The goal of management is to treat symptoms, and optimize one’s function and quality of life. Many primary care physicians are overwhelmed by the extreme presentations, which breed fear, and in turn, avoidance. We need to train our general providers and community members about this diagnosis and basic management, to enhance their comfort and knowledge of resources. A similar training may benefit schoolteachers who struggle to manage 30 children at once, and may not understand the degree of hypersensitivity one with autism may experience, or the depth of their rigidity.

Family-centered care and care coordination within a medical home have been shown to improve healthcare transition rates for these youth.

Their transition poses additional considerations, such as advocating for continued support services, and finding new providers for both mental and physical conditions. It would take an entire novel to discuss the breadth of potential interventions to address this wicked problem. Strikingly, providers who seek additional training to become familiar with managing this population typically must seek such opportunities themselves, and do so on their own time. While providers are undergoing this training, families must take advantage of the toolkits and resources to self-educate and advocate for these youth, to invest in their own care if possible. From the community to national level, legislators hold the power to divert funds toward this, which harbors the potential to both improve patients’ quality of life, and to lessen the burden on the healthcare system.

It is a multiplayer game. We are all responsible. And these are only the first levels. Yet, without enabling the transition of our children’s healthcare, the bottleneck grows more desperate and the wait grows longer. We can no longer ignore the need for early and continued mental health care—the news speaks loudly. It has placed the spotlight on mental health—let’s take advantage of it; let’s invest in our children’s future. It is time to tackle this wicked problem.

Reference
1. American Academy of Child and Adolescent Psychiatry (AACAP). “Child and


Disclosure of Affiliations: no financial disclosures.
Resident Representative, AACAP Triple Board/Post Pediatric Portal Program Committee
AAP Liaison, AACAP Medical Student and Resident Committee
District V Resident Representative, AAP Section on Pediatric Trainees
APA/APAF Public Psychiatry Fellow

Katherine Soe, MD, Pediatrics/ Psychiatry/Child & Adolescent Psychiatry Resident, Indiana University School of Medicine, ksoe@iu.edu.

The Willis Tower (formerly the Sears Tower) is the tallest building in the Western Hemisphere at 110 stories high.

Life Members Reach 200!

No, not 200 years old. But, over 200 lives you have impacted.

Impact.

Since 2010, AACAP’s Life Members Fund has made an investment in awards for over 200 medical students and residents. This includes 17 residents and 13 students in 2018. If you attended the Life Members Dinner at AACAP’s Annual Meeting, you got to meet these young superstar future owls!

Donate.

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.
Membership CORNER

Congratulations to Graduating Residents and Medical Students

Please provide us with your updated contact information after graduation.

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

This Could Be Your Last Issue!

Renewed for 2019? If not, you could be holding your last issue of AACAP News!

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

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Simplify your life

NEWS CLIPS

We send you an email every M, W, F with the need-to-know child psychiatry news.

Email communications@aacap.org with questions.
Welcome New AACAP Members

Humaira Abid, MD, Edmond, OK
Beth Abrams, MD, Woodstock, NY
Sammy Abusrur, Tampa, FL
Maria Aponte, MD, Pittsburgh, PA
Melinda Armstrong, MS, MD, Buffalo, NY
Monica Attia, Arlington, VA
Mahta Baghoolizadeh, MD, Los Angeles, CA
Alyssa Beda, MD, Cleveland, OH
Ramona Mahesh Bhatt, DO, Edmond, OK
Ava Ann Boswell, MD, Woodstock, NY
Sammy Abusrur, Tampa, FL
Alyssa Beda, MD, Cleveland, OH
Humaira Abid, MD
Khadija Akhtar, MD
Deborah Adam, MD
Molly Adams, MD
Cynthia Agrawal, MD
Mehdi Afsar, MD
Jorge Andres Diaz, MD
Amit Jagtiani, MD
Kathryn Alarid, MD
Sara Ahmad, MD
Hannah Allen, MD
Rebecca Alipour, MD
Sam Ally, MD
Lincoln B. Atkins, MD
Matthew Armstrong, MD
Jared H. Atkins, MD
Jonna Atkins, MD
Daniel Anand, MD
Lars Anderson, MD
Eshita Andrade, MD
Marta Anderson, MD
Sara Anderson, MD
Rahul Amonkar, MD
Merylynn Antunes, MD
Katherine Antunes, MD
Dane Jensen, MD
Sarah Johnson, MD
Matthew Kark, MD
Punnet Kathuria, MD
Schyler Lynn Kidd, MD
Paul Kim, MD
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Kathleen Kruse, MD
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Hasan Memon, MD
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Megan O’Brien, MD
Michael Ogata, MD
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Bushra Rizwan, MD
Marissa Robertson, MD
Parostu Rohanni, MD
Ariana Rosario, MD
Sarah Kate Rosenbaum, MD
Rachel Russell, MD
Dinesh Sangroula, MD
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Niralee Shah, MD
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Elizabeth Shelley, MD
Vinta Shivakumar, MD
May Shum, MD
Megan Single, MD
Qiana Smith, MD
Kathryn Stevenson, MD
Lauren Stone, MD
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Farzana Tak, MD
Dominick Trombetta, MD
Micah Turpeau, MD
Sirirat Ularntinon, MD
Devin Van Dyke, MD
Jason Velasco, MD
Christopher Viamontes, MD
Maria Veronica Vigil, MD
Damira Vulas, MD
L. Paul Welder, MD
Jacqueline A. Williams, MD
Winifred Wolfe, MD
Collin Xu, MD
Joshua Zollman, MD
Thank You for Supporting AACAP!

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

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Being an AACAP Owl

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

Benefits: Annual AACAP Membership Dues are optional. A voluntary JAACAP subscription is available for $60. Receive the Owl Newsletter, which contains updates focused around your community!

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

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.
AACAP AWARD SPOTLIGHT:
Leslie Hulvershorn, MD, MSc

2015 AACAP ELAINE SCHLOSSER LEWIS AWARD FOR RESEARCH IN ATTENTION-DEFICIT DISORDER

The Journal award recognized a paper published in JAACAP entitled, Abnormal Amygdala Functional Connectivity Associated with Emotional Lability in Children with Attention-Deficit/Hyperactivity Disorder. I think I reran the analyses on the data for this paper 50 times, so it was so gratifying that all that hard work paid off.

2010 AACAP PHYSICIAN SCIENTIST PROGRAM IN SUBSTANCE ABUSE, SUPPORTED BY NIDA

Project Title: Neural Correlates of Emotion Dysregulation in Youth at Risk for Substance Abuse

The NIDA-AACAP Physician Scientist Career Development Award (K12) allowed for substantial amounts of my time to be covered over a five-year period, so I could be mentored in clinical research and develop as an independent investigator. The mentorship and training that occurred during this award was the most influential experience of my career. I wouldn’t be doing the work I am today without it and am forever grateful for the opportunity.

2010 AACAP PILOT RESEARCH AWARD FOR ATTENTION DISORDERS, SUPPORTED BY AACAP’S ELAINE SCHLOSSER LEWIS FUND

Project Title: An Examination of Corticolimbic Functional Connectivity in Children with ADHD with and without Severe Mood Dysregulation

The Pilot award funded a project examining how the brains of kids differed in those with and without severe temper outbursts. I was the Principal Investigator on a study for the first time, and I learned a tremendous amount about neuroimaging from my mentors. More importantly, it generated pilot data for a larger grant, which in turn generated pilot data for the next larger grant.

2008 AACAP EDUCATIONAL OUTREACH PROGRAM (EOP) FOR CHILD AND ADOLESCENT PSYCHIATRY RESIDENTS

The EOP award allowed me to attend an AACAP meeting for the first time, opening my eyes to the variety of research occurring in the field, and providing an awareness that the AACAP meeting was a great place to showcase that work.

COMMITTEE WORK
Research Committee

I served as a member of the Research Committee as a fellow and again now as a faculty member. It has been a privilege to interact with prominent researchers. We are very involved in promoting junior investigators by reviewing grant applications and planning events at AACAP’s Annual Meeting. I have really enjoyed working together with colleagues to promote up-and-coming researchers.
Earn CME from anywhere, at anytime!

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

✦ Clinical Essentials on Depression
✦ Clinical Essentials on Substance Use Disorder
✦ Current Topics in Pediatric Psychopharmacology: An Online Advanced Course
✦ Free JAACAP CME
✦ Lifelong Learning Module 15
✦ On Demand Douglas B. Hansen, MD, 43rd Annual Review Course

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

Share Your Photo Talents With AACAP News

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

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

If you would like your photo(s) considered, please send a high-resolution version directly via email to communications@aacap.org. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
You’re ready for the next career step.

We’re ready to help you leverage your membership to get there.

AACAP members have a distinct advantage over the typical job seeker. Your member benefits include access to a free online job board, JobSource.

Employers from across the country look to JobSource to seek out the most qualified child and adolescent psychiatrists.

You want your profile and resume to be there when they look. Visit jobsource.aacap.org today to get started.
Get in the News!

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

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

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

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

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

**Production Schedule**

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

**Citations and References**

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

For complete AACAP News Policies and Procedures, please contact communications@aacap.org.

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**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.
CLASSIFIEDS

CALIFORNIA

CHILD AND ADOLESCENT PSYCHIATRIST
San Francisco Bay Area, CA

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

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

www.baca.org

TEXAS

CHILD AND ADOLESCENT PSYCHIATRIST
South Texas

Job Description:
Child and Adolescent Psychiatry Opportunity. Driscoll Children’s Hospital (DCH) is seeking a BC/BE Child and Adolescent Psychiatric physician for full-time outpatient care. This is an excellent opportunity to join a robust practice. The Hospital provides a multidisciplinary, family-centered approach to care that includes a dedicated team of three C&A Psychiatric physicians and support staff. Driscoll Children’s Hospital is a teaching hospital affiliated with Texas A&M University College of Medicine and operates a pediatric residency program with a total of 48 residents each year. Competitive Compensation Package Sign-On Bonus Paid Time Off Holiday Pay CME Allowance Full Benefits Package: Life, Health, Dental, Optical, Retirement Plans Malpractice with Tail Coverage Excellent work/life balance DCH is a 189-bed pediatric tertiary care center with pediatric specialists representing 32 medical and 13 surgical specialties offering care throughout South Texas, including Corpus Christi, the Rio Grande Valley, Victoria, and Laredo. Through the vision and generosity of its founder, Clara Driscoll, Driscoll Children’s Hospital opened in 1953, becoming the first, and remains the only, free-standing children’s hospital in South Texas. We are located on the sunny and beautiful Texas Gulf Coast, just four blocks from Corpus Christi Bay. The city offers a rich blend of culture, amenities, and conveniences in a relaxed atmosphere. Enjoy year-round outdoor recreation fishing, tennis, sailing, golf, and windsurfing.

Job Requirements:
Successful completion of ACGME or AOA accredited residency in Psychiatry that included 1 year of training in child and adolescent psychiatry OR Successful completion of an ACGME or AOA accredited residency/fellowship in child and adolescent psychiatry BC/BE in General Psychiatry and/or Child and Adolescent Psychiatry.

Company: Driscoll Children’s Hospital
Job ID: 12345424
http://jobsource.aacap.org/jobs/12345424

WASHINGTON, DC

CHILD AND ADOLESCENT PSYCHIATRIST

Job Description:
A great opportunity exists for a Child & Adolescent Psychiatrist at Children’s National Medical Center in Washington, DC. KEY RESPONSIBILITIES: The faculty physician is responsible for the care of patients in the hospital and clinics, as well as research, educational and advocacy initiatives as determined by the Division Chief and/or the Center leadership. REQUIRED SKILLS/KNOWLEDGE: Knowledge of current principles, methods and procedures for the delivery of medical evaluation, diagnosis and treatment in the area of expertise. Knowledge of legal and ethical standards for the delivery of medical care. Ability to function independently in evaluating patient problems and developing a plan for patient care. Ability to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team. Ability to advise, supervise and train clinical professionals and/or students in area of expertise. Ability to maintain quality, safety, and/or infection control standards. Demonstrates a personal commitment to Continuing Medical Education and remains current on the developments and progress in his/her subspecialty. Demonstrates knowledge of and complies with legal and ethical standards for the delivery of medical care. BENEFITS INCLUDE: Medical, dental and vision benefits Retirement plans with employer match Life and disability insurance Generous leave policy Four weeks accrued vacation time 10 Administrative days to use for academic purposes AACAP membership reimbursement $2,500.00 per year for other memberships And many more! SPONSORSHIP: We may be able to sponsor Visas for this role.

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Job Requirements:
QUALIFICATIONS: Medical Doctor (M.D. or D.O.) from an accredited medical school. Board certified or board eligible in Child and Adolescent Psychiatry.

Company: Children’s National Health System
Job ID: 12345184
http://jobsource.aacap.org/

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Anonymous (5)
Steve and Babette Cuffe, MD
James C. Harris, MD, and Catherine DeAngelis, MD, MPH
Paramjit T. Joshi, MD
Joan E. Kinlan, MD
Dr. Michael Maloney and Dr. Marta Pisarska
Jack and Sally McDermott (Dr. Jack McDermott, in memoriam)
Patricia A. McKnight, MD
Scott M. Palyo, MD
The Roberto Family
Diane H. Schetky, MD
Gabrielle L. Shapiro, MD
Diane K. Shrier, MD, and Adam Louis Shrier, D.Eng, JD

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www.aacap.org/1953_Society to learn more!
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January 31-February 1, 2020
Westin Long Beach
Long Beach, CA

Co-Chairs: James J. McGough, MD, and Manpreet Kaur Singh, MD, MS

www.aacap.org/psychopharm-2020
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- Advertisers who run ads six issues in a row receive a 10% discount.

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