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The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health. For more information, please visit www.aacap.org.
President’s Statement on the Violent Protests in Washington, DC

WASHINGTON, DC, January 8, 2021—On Wednesday, we all watched the violent protests and vandalism unfold in the United States Capitol with dismay, shock, and horror. What we witnessed was not only dangerous and shameful, it was an affront to our values and our democracy. Lives were lost, and our ability to be proud of what the United States stands for was severely shaken.

The generally passive response the rioters received was radically different than the excessive force used against peaceful protestors earlier this summer. We are not advocating police aggression to the rioters, of course, but rather underscoring systemic racism in our society.

We look to our leaders to lead by example, to lead with honesty, integrity, and decency. Not only do words matter, such that angry and hateful rhetoric has consequences, but behavior also matters. As an organization devoted to the mental health and overall well-being of children and families, we look to the events of January 6 and what led up to them as legacies to our next generation. We cannot let those stand. We must do better. Civility, care, and respect must guide our interactions with each other even when we disagree.

Research shows that children and adolescents are prone to imitate what they see and hear in the news. Exposure to such violence can lead to fear, desensitization, and in some, an increase in aggressive and violent behaviors.

To help children, families, and communities grappling with these senseless acts of violence, we put together the Disaster & Trauma Resource Center. A disaster, be it natural or man made, is frightening to children and adults, alike. It is important to explain the event in words children can understand.


I urge you to share these resources with your patients and loved ones.

Please stay healthy and safe.

Sincerely,

Gabrielle A. Carlson, MD
President, AACAP

NEW! Racism Resource Library

AACAP’s Racism Resource Library that provides anti-racism resources for parents, patients, and clinicians.

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The State of Family Therapy Training in the US (A Survey of Family Therapy Training in US Child Psychiatry Residency Programs)

Rakin Hoq, MD

Family therapy has long been integrated into child and adolescent psychiatry (CAP) training because there often is a strong association between dysfunction in family relationships and a child’s presenting psychiatric symptoms. Furthermore, family involvement in treatment across a wide range of childhood and adolescent psychiatric illnesses leads to better outcomes.

Therefore, family based interventions are critical tools that child and adolescent psychiatrists need to incorporate into their clinical practice. Over time, CAP training programs have placed less emphasis on family therapy, as they have for psychotherapy as a whole, and more on psychopharmacology. The current Accreditation Council for Graduate Medical Education (ACGME) guidelines for CAP training do not include family therapy training among its prescribed milestones for CAP trainees to develop “proficiency” in family therapy but they do not include family therapy among their prescribed milestones for CAP trainees.

While abundant evidence supports family-based interventions as valuable treatments for childhood mental illnesses, minimal literature explores the decreased curricular emphasis on family-based treatment among child and adolescent psychiatrists. Several factors may be contributing to this trend: 1) An increasing prevalence of child and adolescent mental illnesses combined with an inadequate workforce have placed increased time constraints on child psychiatrists, 2) Reimbursement models preferentially cover medication management visits, and 3) The rapid growth of clinical evidence for psychotherapeutic and other neurobiologic treatments. Douglas Rait of Stanford University, one of the few exploring this gradual dissonance within the field, surveyed current CAP trainees in several training programs to assess their impressions of their family therapy training. His study found that most trainees felt that family therapy was a necessary competency for child psychiatrists and was beneficial for patient care, but they also felt that their proficiency in this area was relatively inadequate in comparison to other clinical skills. Additionally a retrospective survey of graduates of Brown University’s Child Psychiatry Fellowship and Triple Board Training Program demonstrated highly positive reports regarding the utility of their family therapy training across a broad range of current practice settings. Thus far, no published study actually quantifies and characterizes the current state of family therapy training curricula offered throughout CAP fellowship programs nationwide.

Therefore, I conducted a small, cross-sectional, seven-question-survey of CAP program directors to assess where our field is in now training child and adolescent psychiatrists in family therapy skills. The survey assessed basic demographics of each training program (size and setting) and then characterized their family therapy curriculums in terms of the type of curriculum (didactic only vs experiential vs a combined approach), the number of hours dedicated to training, the professional designation of those teaching it, if or not trainees participated directly in family therapy, and the program director’s perception of how prepared their trainees were to incorporate family therapy skills into clinical practice. 53 of 139 US CAP program directors responded (38 percent response rate). Of those, 17 percent reported only didactic teaching of family therapy. In addition, over the two years of fellowship, 23 percent of these 53 programs dedicated five or fewer hours to family therapy training. A psychologist or licensed marital family therapist (59 percent) taught the vast majority of these curricula; psychiatrists taught only 25 percent. Social workers or a team of clinicians taught the remaining 17 percent. Another finding was that during training, only 64 percent of these programs indicated that trainees had any direct participation in family therapy while 31 percent stated that their trainees had no direct participation in family therapy during the two years of their fellowship. Overall, for the programs that had at least 11 hours of training dedicated to family therapy teaching. Significantly, direct trainee participation in family therapy was associated with the program director’s perception of trainee preparedness; 79 percent of program directors who felt their trainees were adequately prepared had at least 11 hours of training dedicated to family therapy. Wholesome, direct trainee participation in family therapy was associated with the program director’s perception of trainee preparedness; 79 percent of program directors who felt their trainees were adequately prepared had at least 11 hours of training dedicated to family therapy. Overall, percent of the responding program directors felt that their trainees were adequately prepared to incorporate family therapy skills into their training programs.

We used the data to assess associations. They revealed the following: The hours of training dedicated to family therapy were directly associated with the program director’s perception of their trainees being prepared to incorporate family therapy skills in their practice. To explain, 67 percent of the programs in which program directors felt their trainees were adequately prepared had at least 11 hours of training dedicated to family therapy teaching. Significantly, direct trainee participation in family therapy was associated with the program director’s perception of trainee preparedness; 79 percent of program directors who felt their trainees were adequately prepared had at least 11 hours of training dedicated to family therapy. The program directors perceived that during training, only 64 percent of these 53 programs dedicated five or fewer hours to family therapy training. A psychologist or licensed marital family therapist (59 percent) taught the vast majority of these curricula; psychiatrists taught only 25 percent. Social workers or a team of clinicians taught the remaining 17 percent. Another finding was that during training, only 64 percent of these programs indicated that trainees had any direct participation in family therapy while 31 percent stated that their trainees had no direct participation in family therapy during the two years of their fellowship. Overall, percent of the responding program directors felt that their trainees were adequately prepared to incorporate family therapy skills into their training programs.
This survey has several take away conclusions. Only just over half of program directors who responded actually felt that their trainees were adequately prepared to incorporate family therapy skills into their clinical practice. This, coupled with the guideline of family therapy being considered a CAP milestone, indicates that we need to broadly evaluate our current child and adolescent psychiatry training. Programs with 10 or fewer hours dedicated to family therapy curricula were also much less likely to offer any direct trainee experience in family therapy. It was primarily those programs that devoted more time and could accommodate direct participation in family therapy that had program directors who felt their trainees were prepared to incorporate these skills into their clinical practice.

Obviously, this small survey has several limitations including the low response rate of 38 percent, the fact that the trainee perspective was not surveyed, and that there was a large range of time above the 10 hour mark (11-100 hours) within which this survey was not able to delineate what the impact might be of a low versus high dose of training exposure. In addition this survey did not include questions exploring the barriers to providing family therapy training in programs. This study highlights the need for more clearly delineated guidelines for family therapy training in CAP fellowships that includes a minimum recommendation of both the amount and “type” of hours in CAP curriculums that can ensure that child and adolescent psychiatrists leave training adequately prepared to incorporate these skills into practice.

Given that the nature of modern psychiatric practice often leads to the CAP workforce being focused more heavily on medication management than psychotherapy intervention in daily practice, we need to include this exploration in a larger re-evaluation of the goals of psychotherapy training for psychiatrists. The sum of data in our field points to a family systems lens as being essential in assessing, managing, and treating psychiatric illness. Doing so maximizes optimal outcomes for our patients. The idea is not necessarily to “make child psychiatrists family therapists,” but to ensure that in addition to prescribing, child and adolescents psychiatrists are also equipped to both be psychotherapeutic in their interactions with children and families, and to understand how to therapeutically navigate complex family dynamics in their clinical practice, even if they are in a primarily “prescriber-focused” practice. ■

References


Rakin Hoq, MD, is a Resident-Fellow Member of AACAP Family Committee and 1st year child psychiatry fellow at NYU Grossman School of Medicine. (Rakin is also serving as an American Psychiatric Association Diversity Leadership fellow and serves on the American Psychiatric Association’s Child Council. Otherwise Rakin does not have any disclosures or conflicts of interest).

NEW SCREENSIDE CHATS

AACAP President Gabrielle A. Carlson, MD, talks with Prof. Joan Luby, MD, Washington University School of Medicine, on practical advice on identifying pre-school depression, treatment, and the long-term implications of the condition.

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Measurement Based Care – An Opportunity

There are many things we have had to learn as a professional community in the past year: from navigating months of telehealth visits, to managing a world where school and social contacts move even more firmly into the harsh confines of cyberspace. We have watched our patients and their families go through change and loss that we could not have imagined as we celebrated the start of a new decade. We have had to give up long held beliefs such as the absolute necessity of the face-to-face visit or direct clinical interview, and in doing so we have sometimes discovered passable alternatives, and other times discovered amazing new opportunities. What is sometimes felt lost in the clinical encounter is often gained in the unique chance to see directly into our patient’s homes, and see the world a little more as they see it. A rare opportunity has opened to rethink what we value and what we need in how we approach patient care.

While developing and editing the recent October 2020 issue of Child and Adolescent Psychiatric Clinics of North America on the topic of Measurement Based Care, one could not have imagined the world in which that issue would arrive. Yet the topic itself proves perhaps more important than ever as we are forced to reimagine how we deliver care in our new shared reality where the video encounter ends and to acknowledge how much our patients’ lives may change before the next one begins; a reality highlighting the need for more consistent assessments and more reliable data points from which to make clinical decisions.

Measurement Based Care (MBC) refers to the incorporation of validated, quantitative clinical measures into the process of mental health treatment. These are usually in the form of patient reported outcome measures, and with optimal implementation are tailored to the individual goals and treatment needs of each patient. The value of these measures is not to substitute for clinical assessment, but rather in their ability to provide a consistent stream of symptom and impairment data that can enhance the quality of clinical decision-making.

We recognize that this idea is not new, and the push to increase use of MBC in mental health has been building for over a decade. Resistance has come in many forms, from the unfortunately mistaken belief that a clinical interview obviates the need for standardized measures to the very practical concerns of how to administer and longitudinally track such measures across an entire patient caseload. The value of such data however, not only in the opportunity to draw out symptoms and insights during a clinical encounter, but to monitor the stability of those symptoms between encounters, is undeniable. Fortunately, while the new care models we have all been forced to adopt may have shaken our faith in the inherent value of the clinical encounter itself, a host of modern computer-based platforms that allow remote administration, scoring, and tracking of assessments, may help mitigate the challenges of deploying an efficient and usable MBC infrastructure. Resources such as the aforementioned October issue of the Clinics (edited by members of the Healthcare Access and Economics and Health Information Technology AACAP committees) are filled with a wealth of information on how such computerized platforms can be selected and utilized. This edition also includes chapters on how to apply MBC to the management of specific diagnoses as well as population health problems.

If we as a profession take this opportunity to adopt and incorporate such systems and practices into our care delivery, then we take the steps to build a system of mental health care that not only outlasts the current crisis, but comes out stronger, more reliable, and more effective. We have the opportunity to build a system that challenges underfunding, dismissal, and stigma with data, accountability, and demonstrable improvements. In doing so, we perhaps have the opportunity to add one more bright discovered opportunity for good as we look back over everything that this year has wrought.

---

Dr. Krishna is a child and adolescent psychiatrist at Nationwide Children’s Hospital in Columbus, Ohio.

Barry Sarvet, MD, is a Child and Adolescent Psychiatry Specialist in Springfield, MA, and has over 34 years of experience in the medical field. He graduated from Northwestern U, School of Medicine medical school in 1987.

Dr. Todd E. Peters is the vice president and chief medical officer (CMO) and chief medical information officer (CMIO) at Sheppard Pratt. He completed his residency and fellowship in child and adolescent psychiatry at Alpert Medical School of Brown University. Dr. Peters earned his MD at Pennsylvania State College of Medicine. He has extensive training in electroconvulsive therapy (ECT), and completed the Duke University Electroconvulsive Treatment Training Program. Dr. Peters is double board certified in general psychiatry and child and adolescent psychiatry. Dr. Peters has also served as the Consulting Editor for Child and Adolescent Psychiatric Clinics of North America.
Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award Recap

The AACAP Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award was established with a generous donation from Lisa Yang, in honor of Marilyn B. Benoit, MD, a former AACAP president and staunch advocate for children who have been affected by maltreatment. The award provides opportunities for child and adolescent psychiatry trainees and early-career child psychiatrists, with assistance from mentors who have had experience in the field of child maltreatment, to develop projects designed at enhancing awareness and interest in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention.

As the 2020 recipient of the award, I had the benefit and pleasure of working with Elizabeth Lowenhaupt, MD, Associate Professor in the Department of Psychiatry and Human Behavior and the Department of Pediatrics at Rhode Island Hospital/Brown Alpert Medical School, Chair of the Juvenile Health Committee of the National Commission for Correctional Health Care (NCCHC), liaison for AACAP on the NCCHC Board of Representatives, and Consulting Medical & Psychiatric Director of the Rhode Island Training School, a juvenile detention center in Cranston, RI. With Dr. Lowenhaupt’s mentorship, I was able to complete the project “Healthy Families, Healthy Children: Supporting a System of Care for Families with Children Affected by Maltreatment,” which aimed to address the negative health effects of child maltreatment through a two-pronged approach of direct provision of care and resources to children and families as well as collaboration with other members of relevant systems that interact with children affected by maltreatment.

Landmark studies such as The Adverse Childhood Experiences (ACE) study have demonstrated a clear link between specific adverse childhood experiences (including various forms of maltreatment and household dysfunction) and mental and physical illness later in life, including many of the leading causes of death in adults. Per the U.S. Department of Health & Human Services, in 2018 Rhode Island, a state with 205,213 total children, had 3,918 substantiated cases of child abuse and neglect involving 3,644 unique victims, yielding an overall victim rate (17.8 victims per 1,000 children) that was nearly twice the national rate (9.2 victims per 1,000 children). The Lawrence A. Aubin, Sr. Child Protection Clinic (Aubin CPC) at Hasbro Children’s Hospital, which partners closely with the Rhode Island Department of Children, Youth, and Families (DCYF), provides medical assessment to suspected victims of child maltreatment in Rhode Island and the surrounding states. Based on data collected between April and July of 2019 by Anish Raj, MD (the Triple Board trainee who revived the CPBC last year), patients evaluated at the Aubin CPC wait an average of 5 weeks to establish care with an outpatient mental health provider.

The first prong of the project was aimed at providing support for the families of patients of the Aubin CPC through both short-term family-based early intervention in the Child Protection Bridge Clinic (CPBC) and financial assistance for families seen in the CPBC. The early intervention was modeled after the Child and Family Traumatic Stress Intervention (a 5–8 session evidence-based early intervention implemented within 30–45 days of a traumatic event or disclosure of abuse) and The Family Support Project (an 8-10 session structured family-based treatment offered within a month of initial disclosure of childhood sexual abuse).

I received invaluable supervision from Dr. Lowenhaupt, Sibel Algon, MD (the clinical supervisor of the CPBC), Christine Barron, MD, Amy Goldberg, MD, and Brett Slingsby, MD (child abuse pediatricians at the Aubin CPC), Michelle Rickerby, MD (Director of Family Therapy Training for the Brown University Child and Adolescent Psychiatry fellowship program), and Steven Barreto, PhD (clinical supervisor of the Family Therapy Program, which I participated in from July to September). With their guidance and my enhanced clinical knowledge (through advanced TFCBT training/consultation calls, textbooks, and online resources) that was made possible through the financial support of the award, I was able to provide competent, trauma-informed, family-based integrated care during 29 outpatient appointments (as of October 31st, 2020) in the CPBC with 17 different participants from 6 families with children who were affected by various forms of maltreatment. Of those 29 appointments, 17 were completed virtually and 12 were completed in person. The flexibility in delivery of services appears to have helped with no-show rates, which decreased from ~40% during the prior year’s incarnation of the CPBC to 21.6% from the beginning of this project through October 31st.

The second prong of the project involved supporting the clinical systems that provide care to these families through direct consultation, integration/coordination of care, and educational opportunities.

The Aubin CPC team, which consists of child abuse pediatricians, a nurse...
practitioner, a social worker, nurses, and child life specialists, is an integral part of the system that cares for children affected by maltreatment. From my time embedded within the Aubin CPC two days/week, I have increased my knowledge of the process and content of child abuse pediatricians’ evaluations and recommendations, allowing me to interact more efficiently with the Aubin CPC team, other members of the various systems that care for children and families affected by maltreatment, and those children and families themselves. Knowledge also flowed in the other direction, as I was able to increase the team’s understanding of the mental health consequences of maltreatment through real-time consultation and various educational opportunities, including a >1 hour presentation entitled “At the Border: The Links Between Sexual Abuse, Borderline Personality Disorder, and Psychosis.” This presentation was specifically requested by the team in response to recent and historical clinical conundrums around patients’ disclosures of sexual abuse in the context of psychiatric symptoms. Overall, the increased integration between the Aubin CPC team and mental health providers is expected to lead to improved outcomes for the children and families that we serve.

The project also involved collaboration with community partners. A poignant example of this collaboration came during one CPBC patient’s Multidisciplinary Team (MDT) meetings, which were hosted by Christie Robbins, the Commercial Sexual Exploitation of Children (CSEC) MDT Coordinator from Day One RI, a community agency whose mission “is to reduce sexual abuse and violence while supporting and advocating for those affected by it”. During these MDT meetings, I interacted with members of various community partners, including the Rhode Island DCYF, Tides Family Services, Saint Mary’s Home for Children, The Providence Center, and Child & Family, with all of us coming together to support individual children and their families. Through introductions from Dr. Lowenhaupt and coordination of care with patients’ other providers, I also developed relationships with providers at Family Services of RI, Providence Community Health Center, Ocean Tides, Turning the Corner, Tri-County Community Action Agency, Adoption RI, and Rhode Island College School of Social Work.

This second prong of the project also involved providing financial support for other providers to pursue trauma-focused training and increase their knowledge of effective trauma therapies. With financial backing from the award, five additional providers (one 4th year Triple Board resident and four clinicians affiliated with the Rhode Island Training School) have been able to register for advanced TFCBT training. The clinicians at the Rhode Island Training School provide services at a critical time in the lives of many children who have been affected by maltreatment. Although not all children in the juvenile justice system have been exposed to maltreatment, a significant proportion have been. Provision of appropriate trauma informed care while in the juvenile justice system may be crucial in the important steps towards rehabilitation for this vulnerable population that is disproportionately made up of children of color.

Additionally, the award provided all of the Child Psychiatry fellows and 4th and 5th year Triple Board residents at Brown University with resources aimed at improving their ability to provide trauma-informed care. These resources include individual copies of the books Treating Trauma and Traumatic Grief in Children and Adolescents and DBT Skills Training Manual, as well as Trauma Reaction Cards for use during fellows’ and residents’ work with their own patients. It is my hope that these resources, a quality improvement presentation about the CPBC, and informal discussions about the transformative work that has occurred in the CPBC will inspire my colleagues to continue to expand the CPBC in future years, pursue further knowledge about trauma, and provide more trauma-informed care in their own work.

The 2020 Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award has afforded me the opportunity to pursue my interest in improving the systems of care for children affected by maltreatment. It is my hope that this year’s project sparks increased interest in the field of child maltreatment. Due to child maltreatment’s sinister downstream, intergenerational effects on individuals, families, and societies, the work done to counteract it has exponential returns. Those who have the privilege to work with children and families affected by child maltreatment should know that they are not just treating those who sit in front of them, but many others who will come after them.

References


Dr. Otu completed his psychiatry residency at the University of Miami. He received his medical degree from the Keck School of Medicine at the University of Southern California in 2016. Dr. Otu also received an MBA degree while in medical school. During medical school, Dr. Otu conducted a study investigating the relationship between the patient-centered medical home model of health care and diabetes care. During residency, Dr. Otu was actively involved in providing psychiatry evaluations at a local women’s shelter and more globally he designed health improvement programs that targeted youth in Cameroon and Honduras. He also organized a peer orientation for incoming psychiatry residents at UM regarding the management of agitation and common medical emergencies.

Dr. Lowenhaupt is a pediatrician, psychiatrist, and child and adolescent psychiatrist based out of Rhode Island Hospital/Hasbro Children’s Hospital.
How Pornography Affects Mental Health and Risk Behaviors, and What To Do About It

Paul Weigle, MD

During the disruptions of routines and normalcy for our patients during the COVID-19 pandemic, it seems there couldn’t possibly be anything more to add to the list of our concerns. But an explosion in youth screen time means child and adolescent psychiatrists also need to be cognizant of our patients’ pornography exposure.

The internet has transformed the way youth consume the entertainment industry, from Fortnite and Tiktok, to YouTube and Netflix. The anonymity, affordability, and availability of sexually explicit materials on the internet has helped the US porn industry balloon from no more than $1 billion in 1998 to $13 billion by 2014. Leading video-sharing site Pornhub saw more visits in 2019 than Netflix, Amazon, and Twitter combined, and features over six million free videos of nearly every conceivable variety. These videos typically have little narrative, in which a male protagonist initiates and controls rough, casual sex without use of a condom, while a female’s role is to please him.

The rise of online pornography has also seen a concomitant increase in youth exposure, particularly among adolescents, 90% of whom admit to viewing porn.1 Both unintentional and intentional exposure is common. Viewing often becomes habitual, especially among older male teens, who spend more time online; youth suffering depression; youth suffering from family strife or behavior problems; and those with same-sex attraction. Smartphone ownership greatly enables pornography access, and most online porn is accessed through smartphones as opposed to other tablets and computers.

Exposure to extreme pornography (e.g., content including violence, bondage, sadism, or group sex) is very high, as these categories are as easy to access as more traditional pornographic content. Parents greatly underestimate their teens’ pornography exposure. Pornography engagement serves as a default sex education for many teens, as parents are typically reluctant to educate their children about sex, and most US states don’t mandate sex education in schools. Youth often have a difficult time discerning what aspects of pornography are realistic from what is theater.

There has been an explosion of research on the effects of pornography on youth, with available studies on the pornography in PubMed tripling from 2003 to 2020. Most research involves cross-sectional studies utilizing self-administered questionnaires, as doing experiments on this topic is generally considered unethical. The cross-sectional nature of research typically makes causality difficult to establish. Pornography exposure predicts changes teens’ attitudes towards sex, with views of casual sex and homosexuality becoming more permissive, and greater belief in traditional gender stereotypes, especially negative ones. This may be particularly important, because adolescence is a critical period in the development of sexual identity and behaviors. Adolescents who view pornography are also more likely to engage in sexting, which most often leads to poor outcomes when done outside of a pre-existing relationship.2

Teens learn sexual scripts from pornography, and many imitate what they see in pornography with their real-world partners.3 Pornography viewing may displace sexual activity between teens for many, with overall rates of pregnancy and intercourse in decline. However, pornography exposure among youth is associated with greater likelihood of earlier sexual intercourse, intercourse outside of a relationship, and intercourse without a condom, although parental discussions about safe sex mitigate this risk.4 Viewing violent pornography is associated with abusive behavior including sexual assault among boys and victimization among girls, but the causality of this relationship is especially unclear, and national rates of sexual assault among teens have not increased in recent decades.5 Greater pornography exposure among youth predicts poor body image, sexual dysfunction and decreased relationship satisfaction in later years.6 A growing body of literature demonstrates that a minority of youth endorse symptoms consistent with a behavioral addiction to pornography associated with significant dysfunction and neurophysiological processes similar to those seen in substance use disorders.

Child and adolescent providers should be aware that pornography affects the lives of many of our patients. Youth using computers for learning may be distracted by online pornography during school. Others get into school or even legal trouble for distributing digital pornography to peers. Victims of sexual abuse may use related pornography in an attempt to understand or gain mastery over their trauma. Youth will rarely offer information about their pornography experiences unsolicited, however. Although it may provoke some discomfort, providers should assess pornography use not only in teens for which problem use has already been identified, but also in youth with risky sexual behavior, as well as teens with depression, behavioral problems, or same-sex attraction. Parents should be advised to supervise screen media starting early, using screen-free times (e.g., meals and bedtime) and zones (bedroom, bathroom), as well as parental controls on smartphones and other devices. However, as children age, parents should transition their role from that of a cop to that of a guide, maintaining an open dialogue about screen media choices including pornography, as well as safe sex. These conversations can be difficult for providers and parents alike, but are easier when parents pick the right time to have them.
and place (e.g., in a calm moment while facing the same direction), having a curious attitude, and to avoid emoting shock or judgment. Respect for developmental level demands different language for broaching the topic with younger children (“Have you ever seen something online that made you uncomfortable?”) than with adolescents (“I hear that teens use porn to learn about sex. What do you think?”). Child and adolescent psychiatrists can play an important role in helping our patients and their families navigate access to sexually explicit materials to develop healthy sexual identity, attitudes and behaviors.

References

Paul Weigle, MD, DFAACAP, is associate medical director at Natchaug Hospital of Hartford Healthcare and associate professor of psychiatry at UConn School of Medicine. He serves as the co-chair of the AACAP’s Media Committee, and on the Institute of Digital Media and Child Development’s National Scientific Advisory Board. He can be reached at paul.weigle@hhchealth.org.

2021 AACAP CALL FOR NOMINATIONS

AACAP’s Nominating Committee is presently soliciting nominations for President-Elect, Secretary, Treasurer, and two Councilor-at-Large positions. The deadline for nominations is Monday, March 1, 2021.

You must be an AACAP voting member to nominate yourself or an individual.

You must be a Distinguished Fellow of AACAP to run for President-Elect, Secretary, or Treasurer, and you must be either a Distinguished Fellow or General Member to run for Councilor-at-Large.

If you wish to nominate someone, please send the following to executive@aacap.org:

1. A letter of interest from the nominee with an indication of the office(s) of interest
2. The candidate’s current CV
3. The candidate’s Disclosure of Affiliations Statement
4. (Optional) One nomination letter written in support of the nominee’s candidacy for the position by you or by a colleague

If you wish to nominate yourself, please send the following to executive@aacap.org:

1. A letter of interest with an indication of the office(s) of interest
2. Your current CV
3. Your Disclosure of Affiliations Statement
4. (Optional) One nomination letter written in support of your candidacy for the position by a colleague

Please note, AACAP will only accept one nomination letter per nominee. The job descriptions can be found on AACAP’s website.

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Talking to Each Other: Care Coordination for Youth from Psychiatric Hospital to School

A variety of strategies can support youth and their families during their transition from psychiatric care back to school. Different intensive outpatient, inpatient, and partial hospitalization or residential programs have unique protocols for care coordination and supporting re-entry to the school environment. Strengthening the process for “bridging” care is critical not only for a patient’s mental and academic health but also for the educators, clinicians, and families who seek to provide a protective environment for the youth’s healing. Unfortunately, clinicians, schools and parents/guardians face barriers to this process. Although there is strong evidence to promote spanning the boundaries of institutions and disciplines for improved care coordination, there are no formalized standards of care or practice guidelines for clinicians and educators as patients return to school after a psychiatric emergency.

Youth who have been hospitalized or absent from school due to severe mental illness frequently struggle returning to school. The goal of acute hospitalization is to stabilize youth, but the care must continue post-hospitalization. The first few months following hospitalization is a high risk period for worsening mental health problems. Youth with a history of trauma and adverse life experiences have an increased risk for mental health problems and school failure, with youth with mental illness receiving special education being the highest risk subgroup to not graduate from high school.

Known protective factors during this time include having the support of caring adults. These caring adults can often be found in the home environment, the school environment, or as part of a clinical care team. However, informal discussions and needs-based surveys indicate that school staff are often unaware when their students are absent due to mental illness, and therefore they, along with parents and students, often do not have a plan for “re-entry” and support after hospitalization.

Educators, like healthcare professionals, often experience hurdles in care coordination including scheduling issues, privacy concerns, lack of releases of information, and not knowing there is a reason or opportunity for coordinated care. Scott Barber, teacher and co-founder of the Transition Bridge Program in his district in Berea, Ohio, explains that teachers rarely need to know the details of the youth’s challenges but want to know what they should and should not do to create the best outcomes for the identified student.

One hospital-side solution to improve communication is a change in admission procedures. Instead of seeking permission to touch base with schools after a complete evaluation or team discussion, the social worker obtains permission to reach out to a school guidance counselor upon admission. This allows for more time to make contact, communicate and plan with the patient’s school team for re-entry during the very brief hospitalization.* On the school-side, a transition solution created by the successful BRYT (Building Resilience for Youth in Transition) program in Brookline, Massachusetts has embedded classrooms in affiliated school buildings with clinical and educational staff collaborating in a therapeutic learning environment for youth returning from psychiatric care.

Mr. Barber notes that in his experience educators need to have the clinical side of care demystified so that school teams “do not assume that something transformational occurs in the brief time in the healthcare facility.” Educators understand that if a youth is sent to the Emergency Room and then comes back the next day, there is not truly a lower level of risk for a mental health crisis. “We need to realize that kids with mental illness need all the caring professional adults in their lives to be in communication and stay in communication for as long as is needed.”

The immediate goal of care coordination during re-entry to schools is to support and protect the youth and to better support the family during crisis and recovery. The indirect professional goal of care coordination is to establish or reinforce care coordination processes that may eventually become internal.

“*As a cautionary note, there are reasons to avoid care coordination between clinical and school teams. When identified concerns for care coordination are mentioned, the risks, benefits and alternatives should be discussed thoughtfully in a team meeting with clinicians, family and the patient.
and standardized within the district or school. Risks to care coordination are privacy concerns, stigma regarding mental illness, and cost/time. Barriers to care coordination include time constraints for clinicians or educators, difficulty connecting and scheduling, and uncertainty in knowing with whom to talk. Coordination of care with online school educators represents a specific challenge for healthcare teams. The current COVID-19 pandemic has required flexibility and creativity in communicating with educators that work with youth regardless of in-person, blended, or virtual learning environments.

There are helpful recommendations for clinicians and educators as we think comprehensively about best supporting a youth returning from a psychiatric hospitalization.\textsuperscript{1,2} The Day to Liv – Transition Bridge Program in various districts in greater Cleveland, Ohio has developed a checklist for inpatient and school teams to better assist with the process of transitioning back to school. This checklist has been developed with input from professionals as well as parents. While care coordination is generally achievable by most teams, notable challenges include knowing to initiate care coordination and expecting care coordination to occur.\textsuperscript{9} The Transition Bridge team works to make sure both sides of care (clinical and schools) communicate bidirectionally and know how to establish contact efficiently. Some effective strategies include updating online contact lists on a district webpage and getting releases of information signed upon admission to an inpatient unit. By focusing on consistent, clear communication and planning among the professionals and guardians in the clinical, education and home settings, we create a connected support system to help the youth successfully navigate daily life.

As Mr. Barber emphasizes when talking with and training healthcare professionals and teachers, “Our level of communication must equal our level of concern.” The time we take to close the loop of communication may be worth every non-reimbursable penny and the fatiguing volley of missed calls and voicemail messages. By spanning the boundaries between institutions and disciplines,\textsuperscript{3} a child’s quality of life, or life itself, may be protected.

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\textbf{Transition Bridge Hospital Team Checklist} \\
\textbf{Upon Patient’s Admission to the Hospital} \\
Have parents sign Release of Information forms on admission after providing informed consent. A process for digital signatures and consent are encouraged. Establish contact with school on day one of hospitalization after obtaining consent from guardians and assent from the patient. Begin coordinating as soon as possible with the school for post-discharge needs. As most schools do not have a formalized re-entry process, remain available for guidance and recommendations regarding re-entry Transition Bridge meetings. Note: The work you do may have a ripple effect for students beyond the individual you are supporting currently. \\
\textbf{Upon Student’s Release from Hospital} \\
Inform identified school staff of the date of discharge and anticipated date of return to school. Support school staff by informing parents of the recommended re-entry meeting with the school counselor, parents/guardian, and student on the first day of the student’s return. Be careful to set realistic expectations for families and defer school-related protocol questions to the school staff. The school re-entry meeting may also include Transition Bridge team members and other teaching staff. Remind the school team and parents that schools cannot share medical information about a student’s hospitalization and related circumstances with teaching or operational staff without parental consent. \\
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\textbf{Hospital Team Checklist} \\
\textbullet Social worker serves as the point of contact for the school team. \\
\textbullet Obtain \textit{Release of Information consent} for school coordination on admission by intake nurse. \\
\textbullet Social worker \textit{calls parents on day one of admission} to confirm consent to coordinate with school. Social worker asks patient and guardian to \textit{identify preferred contact at school}. \\
\textbullet Social worker \textit{leaves a message} for the preferred school contact and begins the “phone tag” process on day one of admission. \\
\textbullet Social worker \textit{obtains input from school staff} regarding the patient’s condition and learning needs and provides collateral information to the hospital team. \\
\textbullet \textit{Unit teacher} (if available) seeks to obtain academic records, evaluates the patient on the Unit, and provides observations and recommendations to the doctor and social worker. \\
\textbullet Social worker includes observations and recommendations from the doctor, nurse, activities therapist, parent and patient in discussions about return to school and the patient’s specific needs. \\
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Hospital Team Checklist continued on next page.
**Hospital Team Checklist (continued)**

- Social worker advises **doctor to write a simple letter** (3 brief paragraphs or less) with dates of admission, diagnoses and any special circumstances or needs recommended upon return to school. The letter can cautiously include a recommendation for accommodations or, if suggested by the Unit school teacher, special education evaluation. The social worker faxes (or securely emails) the letter to the identified contact at the school and also provides a copy to the guardian.
- Be clear in the letter and phone communication with the school about strategies to improve re-entry and what information is and is not necessary to disclose.
- Review with the patient and guardian(s) the information that they may want to share and what is not necessary to share with concerned peers and school staff. You can offer tips on how to customize their responses.
- **Customize the communication plan** with consideration to student’s preferences and privacy.
- Let parent(s)/guardian know that school staff have been notified of discharge and anticipated date of return for re-entry meeting.
- Inform outpatient medical team of anticipated date of school re-entry.
- Advise parents to call school contact on the day of discharge to confirm a re-entry meeting.
- **Remind** the outpatient team, school team and family that frequent communication is highly recommended. **Recommend the Transition Bridge team** if available to that district.
- **Remain available** for any questions or concerns that may arise during re-entry to school post-hospitalization.

**Transition Bridge School Counselor Checklist**

**Upon Student’s Release from Hospital**
Schedule Return to School meeting with school counselor, parent(s)/guardian, and student on the first day of student’s return. This meeting can also include Transition Bridge team members and other teaching staff. Reminder that schools cannot share medical information about a student’s hospitalization and related circumstances with teaching or operational staff without parental consent.

**At the Transition Bridge Meeting**
- **Review** the student’s **schedule**.
- Incorporate any **recommendations sent from the hospital** about the student’s return to school.
- **Discuss** what the student/family is willing to share about their support needs.
- Inform student/family that letting teachers and staff know that the student has been struggling with symptoms or situations increases likelihood of student stability and success.
- Remind student/family that the information shared does **NOT** need to include diagnosis or details of hospitalization.
- **Customize the communication plan** as student may want different staff to have different levels of information.
- **Meet face-to-face or virtually** with staff members involved in the student’s school life to let each staff member know that the student is returning and to share agreed upon information. In person communication is highly recommended. Avoid electronic written communication for this sensitive communication. (Transition Bridge Program can assist with this process.) This communication may include:
  - AM/PM transportation
  - Supervisory staff (hall, food services monitors)
  - All scheduled teachers
  - Extra curricular teacher
  - Athletic coach
- Send a **follow-up email** to all communicated staff briefly summarizing the information.
- Let parent(s)/guardian know that staff has been notified and is prepared for a successful student return.
- Schedule follow-up communication **within 3-4 school days** with school staff, family, student, and any outside mental health providers. (Students are at highest risk of rehospitalization during the first 10 days of return.) **Frequent communication is highly recommended.**
- **Remain available** and listen non-judgmentally to school staff who have questions.
For Consideration: Pre-hospitalization Letter
If a student is at school and needs evaluation for mental health risk, consider writing a letter or sending an addendum to the school safety/risk assessment form that the student and guardian can take with them to the Emergency Room describing the school’s account of the student’s functioning. This letter should include the name and contact information of the school counselor in case the student is admitted. If this letter is handed to the parent, you can avoid challenges associated with the Release of Information process and can stay in alignment with FERPA guidelines.

References

Scott Barber, MS, is a parent and educator at Berea-Midpark Middle School and district Transition Bridge Coordinator. He facilitated Youth Mental Health First Aid training for all district employees.

Elizabeth Richmond, LPCC-S, is a self-employed mental health counselor in Cleveland and surrounding suburbs and co-directs the School Mental Health Longitudinal Rotation for CAP Fellows.

Molly Wimbiscus, MD, is a child and adolescent psychiatrist at Cleveland Clinic and director of the School Mental Health Program.

The Day to Liv – Transition Bridge Program is a collaborative program spanning organizations. The program assists and professionally develops school staff and clinical teams in supporting youth who have been psychiatrically hospitalized as they return to school.

The authors have no financial interests to disclose.
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Contact us at cme@aacap.org.

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AACAP’s Annual Meeting—A Resounding Success!

And, in particular, thank you to over 1,000 speakers who put their hearts and souls into making our educational content engaging and rich and who spent far more time preparing than they would have needed to do for an in-person meeting. Your work was heroic!

In the coming pages, you will read about some of our fantastic programming, which engaged attendees for two weeks in October, and even into November. I appreciate hearing from so many of you about how the meeting reconnected you to the field, provided a lot of flexibility to actually engage in even more learning than at an in-person meeting, taught you how effective listening to lectures at 1.5 speed can be, and allowed you to have meaningful interactions with colleagues on our zoom sessions. Of course we all missed the hugs, shared meals, and running into old friends, but I’m optimistic that we will be together again in Atlanta, October 25-30, 2021.

As you read our highlights articles, hopefully you’ll see our themes of resiliency, diversity and inclusion, and a sense of coming together to respond to our current crises and provide the best care for our patients and families. If you didn’t have the opportunity to attend, or still have sessions you’d like to watch, visit AACAP’s Learning on Demand at https://aacap.sclivelearningcenter.com/ to access many hours of this high quality content.

Thank you again to all of those who participated in the virtual Annual Meeting and I look forward to continued engagement in 2021!

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.
Meeting Self-Criticism with Self-Compassion

Desiree Shapiro, MD

Life may be a juggling act: your to-do list may as well be a book chapter; you may be waiting for that extra time to catch up; your family, friends, and work may need more of you; the next obstacle may be waiting around the corner.

Last year presented us with a global pandemic, racial injustices, fires, and other disasters, not to mention the typical personal and professional challenges that are ubiquitous to the human experience. During hard times, it is common for individuals to become harsh with themselves for many reasons, including the misconception that harshness will lead to greater results or make things better. What if we met the harshness with compassion? Self-compassion is like your old friend who brings a smile to your face just thinking of her. Self-compassion isn’t judgmental and doesn’t expect more of you, rather she is kind, understanding, and surprisingly inspirational. At AACAP’s 2020 Virtual Annual Meeting, two sessions gave participants a chance to learn about, and practice, self-compassion during a time when many of us need it the most.

Lianna Karp, MD, and Cordelia Ross, MD, chaired a session titled “The Power of Vulnerability and the Solutions to Keep Us Well: Using Self-Compassion as a Means to Combat Maladaptive Perfectionism” and put a spotlight on our self-critical thoughts. In that session, Drs. Sansea Jacobson, Myo Thwin Myint, Neha Sharma, and Carly Kawanishi shared their powerful stories that celebrated authenticity and the human experience. The opening slides set the tone when the presenters provided personal disclosures, immediately creating a space that felt intimate and courageous. The speakers put a spotlight on self-criticism and maladaptive perfectionism, which was surprisingly common to us as attendees.

Anonymously submitting thoughts of self-doubt and having them displayed for all to see, we witnessed the collective experience of self-criticism later countered with self-compassionate statements for the group to enjoy. This experience allowed us all to be honorary members of what Dr. Karp’s institution calls “team vulnerability.” The discussion from the audience was rich, including spontaneous and poetic words by the one and only, Andrés Martin, MD, MPH. This session brought together a community of trainees and practicing Child and Adolescent Psychiatrists (CAPs) who offered empathy, insights and reflections.

A few days later, Drs. Alicia Barnes, Swapna Deshpande, Paven Lidstone and I offered a wellness session on self-compassion. Using Dr. Kristin Neff’s model, which synthesizes the ideas of many—including Buddhist teachers—self-compassion is composed of three main components: mindfulness, common humanity, and self-kindness.

Mindfulness brings nonjudgmental awareness to one’s experience, rather than pushing away sensations or feelings, mindfulness notices our suffering in order to embrace it with kindness. Our common humanity allows for grounding. We are not alone, and we are part of a larger human experience. Knowing that perfection is an illusion and challenges are part of life, we can lighten up on the comparison mindset. Finally, my favorite, self-kindness: a powerful remedy to the maladaptive perfectionism and self-criticism that put limits on our creativity and well-being.

Self-kindness is treating yourself as you would your friend. How often are you as gentle with yourself as you are with a dear friend? For many of us we offer acceptance, validation, humor, and gentleness to others and receive rejection, minimization, shame, and harsh criticism from ourselves. Shifting this can be transformative.

Combining these components into a self-compassion statement may be useful: “This is stress.” (mindfulness). “Other people feel this way” (common humanity). “May I be kind to myself.” (self-kindness). In our session, we created a discussion about barriers to self-compassion, our system, and our culture. We reviewed and practiced self-compassion strategies including loving kindness meditation, self-compassion statements, letters/poems, and physical gestures such as holding one’s heart or hands. These small and intentional practices of self-compassion may help us and our patients experience more enjoyment and satisfaction. We become what we practice.

If there is any interest in joining a CAP Compassion Collaborative to brainstorm ways to promote kindness and compassion in our work, for our patients, and in ourselves, please email dlshapiro@health.ucsd.edu. And if you have too much on your plate right now but want to stay in the loop, know that there is always a place for you.

Dr. Shapiro is an Associate Clinical Professor at UC San Diego. She leads the UC San Diego CAP Inclusive Excellence Program which aims to grow an inclusive CAP workforce. She serves on the Adolescent Psychiatry Committee.
AACAP’S 67TH VIRTUAL ANNUAL MEETING RECAP

Debating Screen Time

Last year, the pandemic forced children to adapt to virtual learning, and this led to an increase in screen use for both educational and social purposes. This increase in use sparked new discussions on the effects of screen time on youth, and at AACAP’s Virtual Annual Meeting, Edwin Williamson moderated a debate on the effect of screen time on children’s mental health. The panel included nationally-recognized experts in the field, including Kara Bagot, MD, Rasim Diler, MD, Gwynette Frampton, MD, Stephen Schueller, PhD, Shawn Sidhu, MD, and Paul Weigle, MD. The debate followed an “Oxford style” format, beginning with a vote on the proposition: “Screen time is good for children’s mental health.” Following the vote, the team for the proposition gave an opening statement, and the team against the proposition followed with their opening statements. After a round of rebuttals, the floor opened to questions and answers from the webinar audience—which numbered over 300 at its peak. The debate ended with closing statements from each side and a vote at the end.

The debate generated a great discussion before the event and after. This forum represented a different way of bringing current thought leaders together to examine a controversial topic. In this case, we heard many of the finer points regarding screen time and its effect on children’s mental health. Audience members were able to ask clarifying questions and get the experts to speak “off script” in the Q&A section in a way that fostered a collegial atmosphere, despite being a virtual conference experience.

At the end, the two sides tied! Before and after the event, 78 percent disagreed with the proposition that screen time was good for children’s mental health, and 22 percent agreed that screen time is good for children’s mental health.

Disclaimer: The panelists donated many hours of time preparing for this entertaining presentation of views on a controversial topic. The views they presented were not necessarily their own and were meant to present the common arguments for and against screen time.

Edwin Williamson is a Professor of Child and Adolescent Psychiatry at Vanderbilt University Medical Center and the Child and Adolescent Psychiatry Fellowship Program Director.

Shawn Sidhu is an Associate Clinical Professor of Psychiatry and the Child and Adolescent Psychiatry Fellowship Program Director at the University of California, San Diego.

Stephen Schueller is an Assistant Professor of Psychological Science at the University of California, Irvine.

If you have ideas for future debates, please email Edwin.Williamson@vumc.org.
Summary Points FOR the Proposition:

“Contrary to popular wisdom, regular technology use is not a strong or consistent predictor for mental health among children and adolescents:”

- Most studies show association, not causation about potential risks of screen time and mental health.
- Screen time is a gross measure of the different ways that kids use screens now. Studies exploring screen time have not unpacked the different ways in which screens are used and therefore have mixed findings.
- Even when studies do find relationships between screen time and mental health, these relationships are small: much smaller than other factors.
- Population-level estimates with no clear evidence might obscure the fact that some children and adolescents benefit a lot from digital resources.

“Screens provide opportunities for learning, connection, recreation, and intervention:”

- If you take all the things that children and adolescents can do on screens — FaceTime with grandparents; learn a new language; connect with other children and adolescents who share their unique interests in online affinity groups — you wouldn’t want to take these things away.
- Many children and adolescents report the greatest wellbeing on days they connect with others using digital technologies.
- Various digital health interventions exist and over two-thirds of adolescents 14-22 report having used a health app.

“Digital resources may be especially useful for specific populations:”

- Digital resources have been especially useful for LGBTQ+ youth who may have limited access to resources in their communities.
- Technologies may create environments to facilitate social-emotional development and relationships for specific populations such as Autcraft: a Minecraft server for children that have autism and their families.
- Screens may help overcome traditional access barriers to receiving services and may be more acceptable in some populations.

“Screens are necessary in the current world:”

- Rather than debating whether or not screens are helpful, we should talk about how to best use screens to maximize the wellbeing of children and adolescents. If we think about screen time as bad, we lose opportunities to determine ways to ensure reasonable, responsible, safe, and moderate usage of electronic screen media.
- Without screens, the 2020-2021 school year would be a “lost year” for children and adolescents.
- Learning how to navigate the digital world is an important skill that children and adolescents should be learning.

Summary Points AGAINST the Proposition:

A growing body of neurobiological literature is showing:

- Hyperactivation in cognitive control, salience, and processing regions in teens who report receiving fewer “likes” or “followers” in social media.
- Internet addiction disorder has been linked to dysfunctional cortico-subcortical and frontal-striatal interactions, as well as altered visuospatial attentional/sensorimotor skills that worsen impulsivity and disinhibition, while causing an imbalanced hypersensitivity to gain conditions and decreased sensitivity to loss thereby worsening impulsivity and risk-taking behavior.
- Early research out of the Adolescent Brain and Cognitive Development Study (ABC Study) demonstrates diffused cortical thinning in 9-10 year olds with general screen exposure, particularly activities that engage the visual system such as TV or video watching, gaming, and social network activities.

Exposure to unhealthy models:

- Studies examining media portrayal of body image find that peer incongruent feedback of one’s perception of weight status results in hyperactivation of cognitive control regions.
- These differences risk contributing to an eating disorder, especially with the presence of pro-anorexia or “thinspiration” websites.

Growing use of screens:

- The past 20 years have seen a doubling of recreational screen time to over six hours per day, which is twice the amount of time that children spend in school. Youth are missing out on vital developmental windows from social learning, and less outdoor activity is reflected in ever-increasing rates of nearsightedness, obesity, and diabetes.

Acute psychiatric links:

- Children are at risk for inappropriate sexual behavior and exploitation over the internet, and we have all seen cases of predators taking advantage of this.
- Media exposes teens to inappropriate graphic violence and other disturbing content that desensitizes them to violence, decreases empathy and prosocial behavior, and increases aggression.
- Many teens are constantly bombarded with 24-7 cyberbullying to the point where they feel trapped with no way out, depressed and suicidal.
- Content matters too, as demonstrated by a nearly 30% increase in actual deaths by suicide attributed to the Netflix series 13 Reasons Why.

Health disparities:

- African American and Hispanic children are disproportionately impacted by screen time, as their parents are more often working multiple jobs just to make ends meet through no fault of their own. This worsens the health disparities and inequities that are already present in our society.
The Generational Magic of AACAP: Spontaneous Town Meetings

Introduction

The “Life Members Wisdom Clinical Perspectives,” at the 67th AACAP Annual Meeting included five presenters, each describing their experience with physician burnout. The participants included Elizabeth Wagner, Anupriya Schnapp, Martin Drell, David Keith, and Douglas Kramer. Dr. Wagner is a 4th year Triple Board resident, Dr. Schnapp an early career child psychiatrist, and Drs. Drell, Keith, and Kramer late career child psychiatrists.

Also, the Committee on Medical Students and Residents collaborated with the Life Members Committee on, “Medical Students, Residents, and Fellows – Meet Life Member Mentors at 2020 AACAP Annual Meeting.” The trainee chairs were Megan Single and Cordelia Ross, and the late career chairs were Joseph Jankowski and Ellen Sholevar.

In the Wisdom Clinical Perspectives, Dr. Drell along with his other late career co-presenters, Drs. Kramer and Keith (plus Dr. Wagner’s psychiatrist parents), have had very long careers free of burnout. Dr. Drell noted the grave situation in US healthcare, mentioning 40%–78% of physicians report burnout, 350-400 physicians annually commit suicide, plus other signs and symptoms of systemic burnout including early retirement, frequent job changes, increased medical errors, lower patient satisfaction, and the negative health outcomes of physicians. He highlighted a NEJM article that stresses the inherent importance to physicians of intrinsic motivating factors, e.g., autonomy, competence, and relatedness, the systemic availability of which make possible the provision of quality care, and her mirror image, the prevention of burnout.

Regarding the state of US healthcare today, Dr. Kramer asked, “Why haven’t the patients rebelled, why haven’t the doctors rebelled?” Dr. Wagner highlighted the importance of relationships in sustaining her work, including connecting with patients, colleagues, and her family. After being immersed in a month-long rotation in the emergency department, she knew burnout was a systems-level issue. Her parents had equally difficult training rotations, but were working with patients, other physicians, and staff, not spending 8 out of 12 hours in front of a computer.

Dr. Schnapp shared her experience of playing the ever-willing hero, appearing happy while on the verge of burnout. She has found that talking to people about how she is feeling, having courageous conversations with colleagues, and recognizing the issues that may be causing burnout has helped her manage burnout post-residency. She stressed the importance of mentors who helped her find solutions to problems she was facing at work, and in learning to advocate for herself – without feeling guilty for “complaining.”

Dr. Keith said the ingredients preventing burnout for him are skepticism, creativity, and collaboration. “Compliance is orthogonal to responsibility,” he asserted. Orthogonal means ‘at right angles.’ It isn’t the opposite of responsibility; it’s actually a different moral system. By default, a compliance system orients the physician to the organization, not toward the patient. Providing the right treatment becomes secondary to properly entering the order in the electronic medical record. The EMR demands the physician’s full attention as the patient drifts slowly into the mist.

The Experience

The 45-minute live Wisdom Perspectives discussion, and similar interactions in the Medical Student and Resident sessions and breakout rooms, were magical—due to emergent natural healing properties of extended family social groups, the same human biological properties that contribute to the care that physicians are motivated to provide and patients continue to expect. The authors experienced no differentiation between presenters and participants. We were simply colleagues struggling with a systemic illness known as physician burnout, the system being contrary to the values that led all of us to a career in medicine. We came together almost instantaneously, united in our concern for patients and good patient care, and experiencing empathy for current and future child psychiatric physicians.

“We came together almost instantaneously, united in our concern for patients and good patient care, and experiencing empathy for current and future child psychiatric physicians.”
Conclusion: A poem by Dr. Single

In a worldwide pandemic confined to a screen,
So many friends and colleagues wishing to be seen,
virtual AACAP became the next best thing.
Zoom instead of California, ouch what a sting!
But the mentoring must go on and the Owls are still excited,
let the mentors and mentees be united!
Once disappointing and tragic,
the virtual event turned out to be magic.
A more intimate setting with deeper conversation,
Fewer mentees to each mentor set a better relation.
The Owls had so much experience and invaluable advice to share,
This new generation of child psychiatrists will be outstanding, beware!

References

Dr. Wagner received her MD from Tulane University School of Medicine in May of 2017. She completed her undergraduate studies at the University of Chicago, where she received a Bachelor of Arts in Religious Studies. Elizabeth was a member of the Combined MD/MPH Degree Merit-Based Scholarship Award. She also received an AACAP Summer Medical Student Fellowship in Child and Adolescent Psychiatry and was a Tulane Klingenstein Child and Adolescent Psychiatry Medical Student Fellowship Scholar. Elizabeth has been involved in research of the internal perceptions of children’s disruptive behaviors with the Tulane Department of Child Psychiatry.

Dr. Single is a Psychiatry Resident Physician at University of Florida Shands Hospital, Malcom Randall VA Medical Center.

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.
The Path Forward: International Medical Graduates (IMGs): Scholarly Work, Research, and Advocacy in Child Mental Health

International medical graduates (IMGs), an integral part of the United States (US) healthcare system, comprise more than 24% of all active physicians, 30% of all practicing psychiatrists, 36% of all child and adolescent psychiatry (CAP) fellows, and 33% of all psychiatry residents in the US. IMGs have played a significant role over the last 50 years in enhancing psychiatric education, advocacy, research, scholarly work, and practice in the US. Several IMGs continue to make outstanding contributions in the US, serving as prolific leaders in the field of Child psychiatry, with one serving as a past president of the American Academy of Child and Adolescent Psychiatry (AACAP).

IMG trainees often face many challenges in understanding the healthcare system and academia in the US. Furthermore, IMGs who do stay in academia after completing psychiatry training often struggle with knowing how to be involved in advocacy work and be an impactful scholar. The prevailing causal factors at play appear to be deficits in IMG training when compared with the training of American Medical Graduates. More specifically, IMGs struggles with lack of involvement in advocacy, teaching opportunities, and limited to no research experience during their medical school. Additionally, various barriers have been implicated for IMGs, including not limited to: a lack of familiarity with the US healthcare system, impediments to assimilate with the American culture, inadequate awareness about academic opportunities, and the stress of immigration.¹²

This general lack of familiarity with and understanding of the field results in many IMGs facing the challenge of an unclear career path. There are many different pathways, which IMGs should be aware of and begin thinking about during the early stages of their training. They should then be able to knowledgeably identify which pathway will align best with their career goals, identify any barriers to success, avenues for growth, and potential resources to enhance successful transition in their chosen academic careers.

Several IMGs have limited research experience during medical schooling. In order to be a clinical researcher, there are numerous pathways (Master’s in Public Health, Research Fellowships, and Master’s in Science – clinical research, Ph.D. or Post-Doctoral Fellowships) that IMGs should consider. These additional levels of training can be helpful in developing the analytic skills necessary to conduct research. For those who lack past research experience, it is important to think about a scholarly project, which is feasible to do at their level of training, skillset, and available resources. They may start with case reports, literature reviews, and retrospective studies under the guidance of a mentor or senior clinical faculty. IMGs should consider different platforms ranging from the poster and oral presentations to symposiums at the national and international conferences to disseminate their knowledge, expertise, and scholarly research projects. It is also crucial to be well informed about the submission and review process regarding peer-reviewed journals, and the pre-requisites for journals where they are planning to submit their manuscripts. IMGs should consider doing research elective and attending research seminars during psychiatry training to see if they really have the passion, in addition to persistence to continue to work on clinical research.

Mentorship is another essential part of professional and personal growth, which IMGs may not have significant experience. IMGs should identify mentors who have expertise in the same field that falls closely in line with their interests in research, advocacy, or education. Mentors can help their mentees to identify potential research projects, available resources in their institution, and even help them identify funding agencies for their pilot projects or introduce them to local, regional, and national resources. The AACAP also have the Mentor Network, which connects high-quality mentors to medical students, residents, CAP fellows, and early career psychiatrists interested in child and adolescent psychiatry. The AACAP Committee on Medical Students and Residents also organizes various sessions on the mentorship program at the AACAP annual conference.

Last but not least, collaboration is a crucial part of scientific research. Collective working relationships are crucial and have numerous benefits to offer, regardless of whether one’s career focuses on advocacy, research, administrative psychiatry, scholarly activities, or any of the other countless opportunities available to the child and adolescent psychiatrist. As the African proverb reads: “If you want to go fast, go alone. If you want to go far, go together.”
As CAP IMGs, we are entrusted to care for the children and youth, as they are not able to advocate for themselves. With our knowledge and training, we are equipped to be the voices of our patients. We can share our expertise and clinical skills with policymakers, media, and the community we live. We all have certain specific areas that we care deeply about and wish to make a difference. These topics could be related to stigma, access to health care, disparities, shortage of CAP, or many others. IMGs legitimate presence in the US was recently threatened with changes in immigration policy. With the assistance of the AACAP, we took a stand to support the Health Care Resilience Act, protect health care in medically underserved communities, and opposed the establishment of a fixed period of admission and extension of stay procedures for nonimmigrant academic students.

In order for IMGs to be effective advocates, they need to be able to use their knowledge and voices to stop legislation and policies that can have a detrimental impact on the mental health of our patients. IMGs need to share their expertise and personal experiences. They need to learn who their allies are and what organizations or groups are active within the communities that they can collaborate. Learning how to better communicate with legislators and politicians would help assure that their valuable voices are heard. Fortunately, the AACAP Advocacy Committee and the Assembly Legislative Conference can provide the IMGs with the support they require to become successful advocates for their patients and for our profession. IMGs are encouraged to get involved in various committees and organizations at the departmental, local, regional, and national levels to be effective leaders for child mental health advocacy.

The transition of IMGs into academic psychiatry in the US can be fraught with challenges. By identifying and creating awareness about these potential challenges, IMGs may be able to experience smoother transitions into the field and success in their chosen career pathways. A better understanding of prerequisite skills and training, potential cultural challenges, and the importance of mentorship and collaboration are vital to becoming successful in academic psychiatry. With a better understanding of the process of navigating the diverse pathways in psychiatry, IMGs can succeed in leadership, advocacy, research, and other scholarly activities.

References

Dr. Baweja is associate professor of department of psychiatry and behavior Health and Public Health Sciences at the Penn State College of Medicine in Hershey. He is interested in comorbidity between ADHD and internalizing disorders and as integration of pharmacological and psychosocial interventions to improve the long-term functioning of youth with ADHD. He may be reached at rbaweja@pennstatehealth.psu.edu.

Dr. Adam is clinical professor at department of Psychiatry at the University of Missouri, Columbia. She is a member of AACAP Diversity and Culture Committee. She may be reached at adamb@health.missouri.edu.
Fred Seligman, MD, AACAP’s Very Own “Official Photographer” & Volunteer Member Extraordinaire!

by Rob Grant, Director, Communications, Data, Member & WEB Services

Thank you isn’t strong enough sentiment for our very own Fred, Seligman, MD, AACAP’s Official Photographer, un-Official White House Photographer, & member volunteer extraordinaire!

Dr. Seligman served as AACAP’s official photographer from (at least) 2009-2019. This includes Annual Meetings, Assembly meetings, and of course – Legislative Conferences. I mention the Legislative Conference as advocacy continues to play a major role in his career.

He’s memorialized in pictures the spirit of AACAP, its leaders, awardees, attendees, representatives from other organizations, and legislators. He has such an amazing talent for capturing ‘moments’ which is exactly what we want. It’s not the formal photos that remind you how great your event was – it’s the natural moments of fun, excitement, and love that are so important to be documented. He’s done this selflessly and received no financial compensation for his volunteer efforts with AACAP.

From getting up early to staying up for the late-night events, Fred rose to every challenge and delivered the goods as a true professional. Sometimes, just sometimes, I was there to help, but for the most part Fred worked alone – carrying his camera/equipment bag (close to 50 pounds) throughout ballrooms and convention centers, meeting rooms and restaurants. Armed with relentless ambition to grab every shot, and buoyed by a true passion for photography, Fred’s been our guy and we’re all better for it.

As 2019 was Dr. Seligman’s swansong, we thought this was a perfect time to turn the aspect, focus, and lens on Dr. Seligman so that we can celebrate his efforts with the entire AACAP family.

Thank you for your generosity of time, talent, and all that you do!
Armed with relentless ambition to grab centers, meeting rooms and restaurants.

I was there to help, but for the most part professional. Sometimes, just sometimes, challenge and delivers the goods as a true professional. From getting up early to staying up for the late-night events, Fred rises to every challenge and delivers the goods as a true professional. He has such an amazing talent for every shot, and buoyed with a true passion for photography, Fred's been our perfect time to turn the aspect, lens, behind the camera, we thought this was a fitting tribute to all that he's done.

Thank you for your generosity of time, much I enjoy working with you. We're so happy (and incredibly lucky) you continue to share your talents with us. Thank you isn't strong enough sentiment to Dr. Seligman for donating his time and expertise in capturing meaningful moments from decades that remind you how great your event what we want. It's not the formal photos but the natural moments of fun, excitement, and love that are so important to be documented.

KUDOS to Dr. Seligman for donating his time and expertise in capturing meaningful moments from decades that remind you how great your event what we want. It's not the formal photos but the natural moments of fun, excitement, and love that are so important to be documented. FRED SELIGMAN, MD, AACAP'S VERY OWN MEMBER EXTRAORDINAIRE!

"OFFICIAL PHOTOGRAPHER" & VOLUNTEER & MEMBER VOLUNTEER EXTRAORDINAIRE! For our special weapon in capturing the un-Official White House Photographer, MD, AACAP's Official Photographer, Dr. Seligman, thank you isn't strong enough sentiment for our very own Fred, Seligman, MD, AACAP's Official Photographer, FRED SELIGMAN, MD, AACAP'S VERY OWN MEMBER EXTRAORDINAIRE!

MEMBER EXTRAORDINAIRE!
Call for Papers

AACAP’s 68th Annual Meeting takes place October 25-30, 2021, at the Hyatt Regency Atlanta and the Marriott Marquis Atlanta. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by February 16, 2021, or by June 7, 2021 for (late) New Research Posters. The online Call for Papers submission form for the February deadline will be available at www.aacap.org in December 2020, and all submissions must be made online.

Questions? Contact AACAP Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.

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Lecture Series on Improving Health Equity During the COVID-19 Era

Sponsored by the Diversity & Culture Committee, this four-part lecture series explores complex social issues that have been further impacted by the pandemic.

www.aacap.org

In Memoriam

from October 1, 2019 – December 31, 2020

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Ambreene Ahmed, MD
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Ann E. Alaoglu, MD
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AACAP News

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Talking to Children about the Violence in DC: Tips for Parents & Teachers
By David Fassler, MD
January 2021

Once again, parents and teachers are faced with the challenge of explaining disturbing national events to children. Although these are understandably difficult conversations, they are also extremely important. Keep in mind, there is no “right” or “wrong” way to have these discussions. However, here are some suggestions that might be helpful.

1. Create an open and supportive environment where children know they can ask questions. At the same time, it’s best not to force children to talk about things unless and until they’re ready.

2. Give children honest answers and information. Children will usually know, or eventually find out, if you’re “making things up.” It may affect their ability to trust you or your reassurances in the future.

3. Use words and concepts children can understand. Gear your explanations to the child’s age, language, and developmental level.

4. Explain to children that it’s fine to protest and express your opinion. But it’s not OK to hurt people or destroy property.

5. Be prepared to repeat information and explanations several times. Some information may be hard to accept or understand. Asking the same question over and over may also be a way for a child to ask for reassurance.

6. Acknowledge and validate the child’s thoughts, feelings, and reactions. Let them know that you think their questions and concerns are important and appropriate.

7. Be reassuring, but don’t make unrealistic promises. It’s fine to let children know that they are safe in their house or in their school. But you can’t promise children that there won’t be further violent protests or that no one will get hurt.

8. Remember that children tend to personalize situations. For example, they may worry about friends or relatives who live in or near DC.

9. Help children find ways to express themselves. Some children may not want to talk about their thoughts, feelings, or fears. They may be more comfortable drawing pictures, playing with toys, or writing stories or poems.

10. Children learn from watching their parents and teachers. Children will be very interested in how you respond to national events.

January 2021
11. Let children know how you’re feeling. It’s OK for children to know if you are upset or confused by national events. Children will usually pick it up anyway, and if they don’t know the cause, they may think it’s their fault. They may worry that they’ve done something wrong.

12. Don’t let children watch too much television with violent or upsetting images.

13. Children who have experienced trauma or losses in the past are particularly vulnerable to prolonged or intense reactions to news or images about violent protests. These children may need extra support and attention.

14. Monitor for physical symptoms including headaches and stomachaches. Many children express anxiety through physical aches and pains. An increase in such symptoms without apparent medical cause may be a sign that a child is feeling anxious or overwhelmed.

15. Children who are preoccupied with questions about violent protests should be evaluated by a trained and qualified mental health professional. Other signs that a child may need additional help include:

● ongoing sleep disturbances
● intrusive thoughts or worries
● recurring fears about violence, leaving parents, or going to school.

If these behaviors persist, ask your child’s pediatrician, family practitioner or school counselor to help arrange an appropriate referral.

16. Although many parents and teachers follow the news and the daily events with close scrutiny, many kids just want to be kids. They may not want to think about elections, politics or what’s happening in DC. They’d rather play ball, climb trees or go sledding.

Protests which become violent are not easy for anyone to comprehend or accept. Understandably, many young children feel confused, upset and anxious. As parents, teachers and caring adults, we can best help by listening and responding in an honest, consistent and supportive manner.

Fortunately, most children, even those exposed to trauma, are quite resilient. Like most adults, they will get through these uncertain times and go on with their lives. However, by creating an open environment where they feel free to ask questions, we can help them cope and reduce the risk of lasting emotional difficulties.

David Fassler, MD is a child and adolescent psychiatrist practicing in Burlington, Vermont. He is also a Clinical Professor of Psychiatry at the University of Vermont Larner College of Medicine, and member of the Consumer Issues Committee of the American Academy of Child and Adolescent Psychiatry.
AACAP and AACP Partner to Unify CALOCUS and CASII Assessment Instruments

Washington, DC, December 15, 2020 – The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) are pleased to announce their partnership in delivering a new assessment tool for children and adolescents.

AACAP and AACP, in a joint effort, unified the Child and Adolescent Level of Care Utilization System (CALOCUS) and the Child and Adolescent Service Intensity Instrument (CASII) into a single instrument: the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) for ages 6-18.

The CALOCUS-CASII is a standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their family, and guides provision of ongoing service planning and treatment outcome monitoring in all clinical and community-based settings. Training in utilization of the CALOCUS-CASII is scheduled to be available both in person and online. The CALOCUS-CASII is also part of the “Level of Care Utilization System (LOCUS) Family of Instruments” lifespan suite which includes the Level of Care Utilization System (LOCUS) for those over 18 as well as the Early Childhood Service Intensity Instrument (ECSII) for those 0-5 years of age.

Current CALOCUS and CASII Users

The new CALOCUS-CASII includes harmonized descriptive language within the tools to merge the two instruments into one. The dimensions, service intensity levels, scoring, and scoring algorithm are fundamentally unchanged.

Current users of the CASII and the CASII online training can continue to use the existing materials, pending the release of the new tool and the updated online training that incorporates the new language.

Current users of the CALOCUS, including the Deerfield online platforms and scoring algorithms, may continue to use those materials as well, pending the release of the new tool and updated online materials that incorporate the new language.

Visit [https://www.calocus-casii.org/](https://www.calocus-casii.org/) to learn more.

For more information or questions regarding current and future training of the LOCUS, CALOCUS-CASII, or the ECSII, please contact the corresponding office below:

**Level of Care Utilization System (LOCUS)**

Copyright American Association for Community Psychiatry (AACP)

projectcoordinator@communitypsychiatry.org
Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)
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clinical@aacap.org

Early Childhood Service Intensity Instrument (ECSII)
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American Academy of Child and Adolescent Psychiatry
The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children’s mental health. For more information, please visit www.aacap.org.

American Association for Community Psychiatry
The mission of the American Association for Community Psychiatry is to promote health, recovery and resilience in people, families and communities by inspiring and supporting community psychiatric care providers, and in transforming behavioral health care. www.communitypsychiatry.org.
Fetal Alcohol Syndrome (FAS)

Fetal Alcohol Syndrome is a condition that develops in a baby exposed to alcohol before birth. A child with fetal alcohol syndrome may have specific abnormal facial features, small head size, and problems with development including delayed language, learning, and poor impulse control. Children with fetal alcohol syndrome are at high risk for problems such as Attention-Deficit/Hyperactivity disorder (ADHD), intellectual disability, learning problems, and emotional issues. Early diagnosis and intervention are important and helpful for children with fetal alcohol syndrome to prevent possible behavioral disorders and help with learning.

Children with Fetal Alcohol Syndrome have:

- Abnormal facial features
- Low weight and/or height before birth or after birth
- Small head size
- Abnormalities of their brain development that could cause seizures
- Language or learning problems, and/or intellectual disability
- Significant impulsivity or behavior problems

Abnormal facial features in children with Fetal Alcohol Syndrome include two of the following:

- Small eye openings
- Smooth area between nose and above upper lip (philtrum)
- Thin upper lip
- Flat nose bridge

Children with Fetal Alcohol Syndrome are at high risk for the following:

- Attention-Deficit/Hyperactivity Disorder
- Intellectual Disability
- Seizure Disorders
- Anxiety Disorders
- Language and learning problems
- Psychosis (hearing voices or seeing things that are not there)
- Impulsive behaviors and behavioral disturbance

Children can be diagnosed with partial forms of fetal alcohol syndrome if they show the abnormal features even when there is no clear proof that their mother drank alcohol during pregnancy. Some children with partial fetal alcohol syndromes show only some of the features. This maybe called “fetal alcohol effects.” When a pregnant person drinks alcohol later in pregnancy, sometimes the physical facial features do not develop in the child, but the other problems still happen.

Frequently Asked Questions

What types of problems do children with fetal alcohol syndrome often have?

- Problems making friends with other children their own age because they may come across as younger than their age or unable to share and take turns
- Difficulties in school due to their learning lagging behind other children in their grade
- Impulsive behaviors, short attention span, and hyperactivity
- Problems with other adults because they may act like younger children
Why does drinking alcohol during pregnancy cause fetal alcohol syndrome in a child?

When a person drinks alcohol during pregnancy, it acts as a toxin and interferes with the normal growth and development of the brain and body of the developing infant.

What is the best way to prevent fetal alcohol syndrome?

Make sure that people who can become pregnant or are already pregnant learn that drinking alcohol while pregnant can be potentially harmful to their babies. Anyone who is pregnant should have regular care throughout the pregnancy. If a pregnant person has a problem with using alcohol and cannot stop using, substance use treatment during pregnancy should be offered.

Can children with fetal alcohol syndrome improve?

Growth and weight may become normal, but having short stature and intellectual limitations may continue into adulthood. Many social, educational and behavioral problems in children with fetal alcohol syndrome can get much better with help:

- ADHD can be treated with medication and therapy
- Language and learning problems can be improved with tutoring, speech and language therapy, and special education services
- Social skills can be improved with therapy and social skills groups
- Family education and support can be very helpful in easing the problems of children with fetal alcohol syndrome

What you can do if you suspect that your child may have fetal alcohol syndrome?

- Talk to your pediatrician or a mental health professional and discuss any and all concerns
- Ask for a referral to an expert to evaluate your child for fetal alcohol syndrome

Related Facts For Families

- Attention Deficit Hyperactivity Disorder
- ADHD and the Brain
- Drinking Alcohol in Pregnancy (Fetal Alcohol Effects)
- Intellectual Disabilities

Resources you can use to learn more about fetal alcohol syndrome and get support:

- The Centers for Disease Control (CDC)
- National Organization on Fetal Alcohol Syndrome – (800) 66-NOFAS

# # #

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

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

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 9,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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Job Description:
The Yale Child Study Center is an opening for a full-time board certified or board eligible child and adolescent psychiatrist dedicated to a career in academic medicine. The mission of the Yale Child Study Center is to improve the mental health of children and families, advance understanding of their psychological and developmental needs, and treat and prevent childhood mental illness through the integration of research, clinical practice, and professional training. The Child Study Center is committed to recruiting, supporting and encouraging the most gifted clinicians, researchers, and leaders in the field today as well those in succeeding generations in the service of its clinical, research, training, policy, and prevention agendas. Yale University is an Affirmative Action/Equal Opportunity employer. Yale values diversity among its students, staff, and faculty and strongly welcomes applications from women, persons with disabilities, protected veterans, and underrepresented minorities.

Job Requirements:
This clinical ladder track faculty position will be at the level of Assistant or Associate Professor. Successful candidates will be excellent clinicians and educators with interest and experience in inpatient child psychiatry including working on an inpatient child psychiatry unit, emergency service consultations, and from time to time consultations to the pediatric inpatient units. Specific clinical services include psychiatric evaluations, medication management, clinical consultation with interdisciplinary team members, and provision of teaching to trainees and professionals of multiple disciplines. Medical education is a critical part of this role, providing skills to medical students, residents and fellows regarding diagnosis, medication management, and inpatient care of youth. Applicants should upload a cover letter, CV, and three letters of recommendation to Interfolio using this link: http://apply.interfolio.com/82221. Review of applications will begin immediately and continue until the position is filled.

FOR YOUR INFORMATION

CONNECTICUT
Company: Yale University Child Study Center (1198705)
Title: Assistant/Associate Professor, Inpatient Child Psychiatry
Job ID: 14235025
URL: https://jobs.source.aacap.org/jobs/14235025

FLORIDA
Company: Lee Health (1233957)
Title: Golisano Children’s Hospital of Southwest Florida (Lee Health) is seeking a Pediatric Psychiatrist!
Job ID: 14241555
URL: https://jobs.source.aacap.org/jobs/14241555

Job Description:
Position Information: Lee Physician Group (LPG) – Pediatric Behavioral Health is seeking a full time BC/BE Child and Adolescent Psychiatrist to join our dynamic multidisciplinary team. Candidate for this position must have completed an Adolescent and Child Psychiatry Fellowship from an ACGME accredited program. Applicant must hold a current Florida license or be eligible for licensure. This practice is comprised of 3 psychiatrists, 5 Clinical Psychologists, 2 licensed clinical social workers, 2 mental health workers, 3 social workers, neurology, developmental, and several other critical support staff. Practice based experience in working with developmental medicine is a plus. Potential plans to expand with consultative liaison services and partial hospital program – experience in these areas is preferred. This main practice location is across the street from Golisano Children’s Hospital in Fort Myers, Florida. EPIC is the electronic medical record. Call for this position with full complement is 1:4 weekends. Benefit Highlights: Offers a competitive compensation package with salary and bonus opportunities Generous paid time off Sign on bonus & relocation package Malpractice through sovereign immunity 403(b) retirement plan with match Short term/long term disability Fort Myers is minutes away from Sanibel Island, Captiva, and Naples. This area is also centrally located between three of Florida’s major cities, Orlando, Tampa, and Miami. If you are interested in learning more about this opportunity, please e-mail your CV to our Physician Recruitment Office at physicianrecruit-ment@leehealth.org.

FLORIDA
Company: Advent Health Medical Group: Central Florida (1146159)
Title: Medical Director, Child and Adolescent Psychiatry Advent Health for Children - Orlando
Job ID: 14188226
URL: https://jobs.source.aacap.org/jobs/14188226

Job Description:
Advent Health for Children is seeking a dynamic, energetic and experienced Child and Adolescent Psychiatrist to lead our team based at the Walt Disney Pavilion (website) in Orlando, Florida. The new Medical Director would help establish our program in our Central Florida area and develop our team including a nurse practitioner, clinical psychologist, LMHC, RN, and a care navigator. Majority of time will be in a clinical capacity, but physician will have some dedicated time for administrative responsibilities including working with community partners. New physician will work to develop pathways for our patients to be seen quickly from our inpatient floors and/or the emergency department. This is an outpatient opportunity with a dedicated space just north of our Children’s Hospital campus near downtown Orlando. We have a robust Developmental and Behavioral Pediatrics program, neuropsychology, a pediatric residency program, and a full team of over 200 subspecialists at Advent Health for Children. We have a network of 30 hospitals in the state with an extensive outreach system as well. This includes multiple outpatient locations with a multidisciplinary presence. We deliver approximately 23,000
FOR YOUR INFORMATION

babies per year throughout our system. Requirements of the position: Fellowship in Child and Adolescent Psychiatry At least 5 years’ experience post fellowship Diplomate of the American Board of Psychiatry and Neurology Board Certification in Child and Adolescent Psychiatry Demonstrable skills in judgment, management, and decision-making. “Team player” mentality with ability to build relationships with community physicians Ideal candidate will have program building experience or experience in a well-developed program. Working with an expanding and committed children’s hospital, an established and successful pediatrics subspecialty group with a strong referral base, a family-centered practice atmosphere, and a competitive benefits / compensation package are just a few of the many reasons why this is an excellent career opportunity to consider. Hospital Description Our Walt Disney Pavilion at Advent Health for Children is a full service, tertiary children’s hospital with over 200 dedicated pediatric beds, more than 30 pediatrics ICU beds with a dedicated pediatrics ICU, a 102 bed NICU, 17 bed pediatric emergency department and state-wide pediatric network and transport system. We started our comprehensive pediatric open-heart program in 2012 and have a strong track record of positive outcomes. We also have several key destination programs including our level IV Epilepsy program, the region’s only BMT and solid organ transplants including kidney and liver, and we increased Orlando area NICU beds to 150 totals in 2017. Our unparalleled network consists of 30 hospitals across the state with one children’s hospital at the center totaling over 23,000 births and several extremely successful pediatric subspecialty programs including outreach clinics. These 30 hospitals refer patients for tertiary and quaternary services to our main location near downtown Orlando. Our newest program has brought pediatric liver transplant services to Central Florida. In 2019 and 2020, Advent Health for Children is recognized by US News and World Report as the best Children’s Hospital for newborn care in Florida. We are also recognized by The Leapfrog Group as a top Children’s Hospital for quality and safety, and we are a magnet designated hospital for nursing care. Practice Description This is an employment opportunity that includes the benefits of call coverage and competitive compensation. Other benefits include occurrence-based malpractice coverage, paid leave days, CME days and allowance, 403b retirement plan, health insurance for physician and family, and relocation allowance. This practice is a part of Advent Health Medical Group (AHMG). AHMG is a sister organization of Advent Health which employs 700+ physicians in 60+ specialties. This aligned model and practice management experience provides the opportunity for the physicians to focus on the clinical aspects of medicine. Location Description Advent Health for Children is conveniently close to many gorgeous homes, downtown urban living, shopping, and great schools. As the most visited American city in 2014, Orlando has world-class attractions including Universal Studios, Walt Disney World, and numerous beaches. Orlando is home to major league soccer (Orlando City Lions), NBA basketball (Orlando Magic) as well as University of Central Florida sports. The city also has many public and private universities and colleges. The newly built Dr. Phillips Center for Performing Arts hosts variety of musical and theatrical performances throughout the year.

MARYLAND/VIRGINIA

Company: Kaiser Permanente - Mid Atlantic Permanente Medical Group (890794)
Title: Child Psychiatrist - Metro DC (Rockville, MD and Woodbridge, VA opportunities)
Job ID: 14223248
URL: https://jobsource.aacap.org/jobs/14223248

Job Description:
Join a Leader in Integrated Healthcare Delivery - Kaiser Permanente Mid Atlantic! The Mid Atlantic Permanente Medical Group is seeking Child Psychiatrists to join our growing practice: Adult/Child Opportunity • .80 FTE (32 hrs./wk.) - Rockville, MD Child Psychiatry Opportunity • 1.0 FTE - Woodbridge, VA • Practice in a large, multi-specialty group of over 1700 physicians and enjoy the many benefits of practicing in our integrated delivery system: • Robust, integrated medical information system • Team approach to providing care with easy access to therapy services and clinical pharmacist • Reasonable, predictable schedules with video medicine capability • Clinical autonomy with excellent sub-specialist support • Energetic focus on excellence and patient centered service, quality, safety, and patient flow • Pension program, 100% paid medical/dental package and occurrence based malpractice coverage

Job Requirements:
Requirements BE/BC in Adult and Child Psychiatry. Medical licensing in Virginia, DC, and Maryland. Questions, please email cooper.j.drangmeister@kp.org.

MASSACHUSETTS

Company: Boston Children’s Hospital (881542)
Title: MEDICAL DIRECTOR, COMMUNITY BASED ACUTE TREATMENT PROGRAM
Job ID: 14223345
URL: https://jobsource.aacap.org/jobs/14223345

Job Description:
We are seeking a child and adolescent psychiatrist (CAP) who will be responsible for overseeing our 12-bed CBAT unit, which cares for youth with a wide range of psychiatric disorders. We are looking for a physician interested in working in the intensive psychiatric care setting. There is the opportunity for involvement in quality assurance and performance improvement initiatives. We are looking for collaborative individuals who can build working partnerships across disciplines and departments. This is an ideal position for the CAP aiming to work in an intensive psychiatric care setting to significantly impact the care of children and their families facing troubling psychiatric illnesses.

Job Requirements:
Candidates must be board eligible/certified in general and child/adolescent psychiatry. All positions will include a Harvard Medical School appointment, which will be at least one rank below professor with salary dependent upon experience and qualifications. Women and minorities are encouraged to apply. CV and brief statement detailing relevant experience should be submitted electronically to Patricia Ibeziako, MD, Associate Chief for Clinical Services, Department of Psychiatry, Boston Children’s Hospital, at patricia.ibeziako@childrens.harvard.edu Boston Children’s Hospital is an Affirmative Action/Equal Opportunity Employer.
MASSACHUSETTS

Company: Boston Children’s Hospital (881542)
Title: INPATIENT AND ACUTE RESIDENTIAL CAP
Job ID: 14244568
URL: https://jobsouce.aacap.org/jobs/14244568

Job Description:
We are seeking full-time child and adolescent psychiatrists to join a robust multidisciplinary team of psychiatrists, social workers, and nursing staff in expanding intensive psychiatry services for youth facing challenging psychiatric disorders. We will be opening a new inpatient psychiatry unit to our Waltham campus. This unit will complement our well-established 12-bed community-based acute residential treatment unit on same campus as our inpatient psychiatry unit in Boston. As such, these positions will offer the unique opportunity to help shape the development and implementation of critically needed new intervention services in an academic Department that is expanding its hospital footprint. We are looking for individuals with a collaborative nature who can build working partnerships both within and outside our Department. This is the ideal position for the physician wanting an academic career as a psychiatric hospitalist.

Job Requirements:
Applicants for these positions must be board eligible/certified in general and child/adolescent psychiatry. All positions will include a Harvard Medical School appointment, which will be at least one rank below professor with salary dependent on experience and qualifications. Women and minorities are encouraged to apply. Boston Children’s Hospital is an Equal Opportunity / Affirmative Action Employer. Qualified applicants will receive consideration for employment without regard to their race, color, religion, national origin, sex, sexual orientation, gender identity, protected veteran status or disability.

MICHIGAN

Company: Helen DeVos Children’s Hospital (982608)
Title: Child and Adolescent Psychiatrist
Job ID: 14192282
URL: https://jobsouce.aacap.org/jobs/14192282

Job Description:
Helen DeVos Children’s Hospital, the lead organization for the West Michigan Mental Health Community Collaborative, offers an excellent opportunity for a full-time BC/BE Child and Adolescent Psychiatrist. The new partner will enjoy being part of a growing program with solid mentorship, stable leadership, and hospital administration support. A large team: 3 child psychiatrists A parent educator 11 pediatric psychologists We collaboratively evaluate and treat: children with complex medical illnesses developmental disabilities Autism How do we treat: consult-liaison work an outpatient consult bridge clinic psychiatric evaluations – in-patient and outpatient Contact: Lisa Lopez In-house Physician Recruiter Helen DeVos Children’s Hospital Lisa.lopez@spectrumhealth.org 616.486.2390 For more information, visit helendevoschildrens.org.

Job Requirements:
Board Certified/Board Eligible

MICHIGAN

Company: Merritt Hawkins (1096672)
Title: Section Chief Of Psychiatry: Opportunity For Leadership And Career Growth In The Midwest
Job ID: 14178951
URL: https://jobsouce.aacap.org/jobs/14178951

Job Description:
Central Michigan University College of Medicine and CMU Medical Education Partners are seeking an experienced candidate with proven leadership abilities and an academic pedigree to serve as Section Chief of Psychiatry. This is a wonderful opportunity that will allow the incoming physician leader to build programs and make an impact. Mentoring junior faculty in an academic and scholarly areas and clinical professional development is a key element of the position. The department consists of ten attending psychiatrists, 24 residents and four child and adolescent fellows. OPPORTUNITY HIGHLIGHTS:
• Opportunity for tremendous career growth—including into a chair role as the section continues to grow
• Ability to make a name for yourself and help build the reputation of the program at a new medical school
• Option for inpatient, outpatient, or both
• Highly competitive compensation—100th percentile of the AAMC
• Excellent work-life balance—residents take primary call
• Providers with any psychiatry subspecialty will be considered
• Qualified and interested candidates may also be considered for the Child and Adolescent Fellowship Director or junior faculty positions. The practice benefits tremendously from residing in Saginaw Township and the Great Lakes Bay Region, an ideal location in Mid-Michigan that offers a community-based atmosphere to its patients and providers. A beautiful riverfront town near Michigan’s eastern shoreline, this family-friendly region is a wonderful place to live and work. Saginaw County is the home of Frankenmuth, one of the State’s leading travel and leisure attractions. COMMUNITY HIGHLIGHTS:
• A low cost of living and great housing options
• Physician-friendly state
• Excellent public and private schools
• An abundance of outdoor recreation, including a variety of water activities
• Symphony, art museums and accredited children’s museums and children’s zoo
• OHL Hockey and Minor league baseball are family friendly activities
• Convenient access (60 minutes) to metro Detroit and additional metro areas
For immediate consideration, please inquire with an updated copy of your CV so we can discuss the position by phone. Also, inform me of your best available times to speak. I look forward to your reply and thank you for your review. Please do not delay as we anticipate a significant response. Please contact Allison Bunnell at medcareers@merritthawksins.com or at 866-406-0269 and reference PSY-52086/

NEW JERSEY

Company: Cooper University Health Care (1228540)
Title: Section Chief Of Psychiatry: Opportunity For Leadership And Career Growth In The Midwest
Job ID: 14124453
URL: https://jobsouce.aacap.org/jobs/14124453

Job Description:
The Department of Psychiatry and Behavioral Health at Cooper University
Health Care and Cooper Medical School of Rowan University (CMSRU) are expanding clinical services, teaching and research programs, and innovative population health initiatives. CUH/CMSRU has openings for two faculty positions in Child and Adolescent Psychiatry (CAP). These faculty positions offer unique opportunities to combine clinical care with teaching, scholarly activity, services innovation, and administrative leadership. One of these positions is for Division Chief of CAP which includes program development, leadership of a NJ state-funded program providing psychiatric consultation and care coordination to pediatric patients referred by primary care providers, oversight of medical student teaching and adult psychiatry training in CAP, and direct patient care. Building upon Cooper’s strong foundation of community-focused and hospital-based services, and CMSRU’s nationally recognized mission to improve the health of underserved communities, the Department is embarking on an exciting plan to expand ambulatory practices throughout Southern New Jersey, to develop a comprehensive population health informed integrated behavioral health program, and to link with community-based health/mental health providers in Camden and surrounding counties. The health system is investing in expanding into a newly acquired outpatient building near the Main Hospital which will be home to a new Division of Child, Adolescent and Family Services. This multispecialty program will provide integrated care to patients from Camden and surrounding communities. Appointment and rank will be commensurate with experience. Candidates should be eligible for or have active ACGME board certification in Child and Adolescent Psychiatry and be eligible for medical licensure in New Jersey. The responsibilities will include teaching medical students, residents, and other trainees; clinical research; clinical service and program development; and shared duties with other members of the department. We offer competitive academic compensation and benefits. Applicants should submit a letter of interest and curriculum vita to Anthony L. Rostain, M.D., M.A., Professor and Chair/Chief, Psychiatry and Behavioral Health, Cooper University Health Care; Rostain-anthony@cooperhealth.edu. Cooper University Health Care is committed to affirmative action, equal opportunity, and the diversity of its workplace.

**OHIO**

**Company:** Nationwide Children’s Hospital (1130346)

**Title:** Child and Adolescent Psychiatrist

**Job ID:** 14269251

**URL:** https://jobsource.aacap.org/jobs/14269251

**Job Description:**

Nationwide Children’s Hospital and the Department of Psychiatry at The Ohio State University College of Medicine are currently seeking talented BE/BC Child and Adolescent Psychiatrists to join our Division of Child and Adolescent Psychiatry and team of Behavioral Health Services professionals. We have a diverse range of opportunities available and offer the unique ability to tailor positions to meet your individual interests. There is need in recruiting for Emergency/Crisis Psychiatry and Youth Crisis Stabilization positions. If you or any of your colleagues are interested in applying or discussing this opportunity, please contact: Megan Rhodes, M.B.A. Practice Plan Coordinator, Psychiatry

Megan.Rhodes@NationwideChildrens.org (614) 722-6882 You should also feel free to contact: David Axelson, M.D. Chief, Department of Psychiatry

David.Axelson@NationwideChildrens.org. All inquiries and referrals will remain confidential.

**Job Requirements:**

The ideal candidate should have excellent clinical, educational and administrative skills. An interest in clinical research is encouraged but not required. At a minimum, candidates should be eligible for a Clinical Assistant Professor appointment. The position offers a competitive salary and excellent benefits package. The candidate must be eligible to obtain a license to practice medicine in the state of Ohio.

**Job Description:**

The Cleveland Clinic’s Neurological Institute announces a search for Child and Adolescent Psychiatrist. The Department is one of four departments within the Neurological Institute (the other three are the Departments of Neurology, Neurosurgery, and Physical Medicine and Rehabilitation). These departments reflect the ongoing rapid growth of the Neurological Institute’s activities at Cleveland Clinic’s main campus and across its regional health system. The Chair of the Department of Psychiatry and Psychology will lead the clinical, education, and research activities related to behavioral health at Cleveland Clinic’s main campus, as well as more than 250 psychiatric inpatient beds spread across five regional hospitals and outpatient clinics located at 20 regional multi-specialty outpatient centers. Currently there are approximately 100 psychiatry and psychology faculty who have primary or joint appointments in the department, as well as 40+ APPs and 30+ social workers making the Department of Psychiatry and Psychology the largest department within the Neurological Institute. There is also a significant outpatient expansion goal to recruit a minimum of 45 faculty in the next 5 years. The faculty represent a variety of models, including NIH supported investigators, academic clinician educators, and full-time clinicians. The Department maintains nationally/internationally recognized programs in virtually all areas of psychiatry and psychology, including research on DBS, TMS, ECT, lithium, ketamine and esketamine. Our research personnel have been highly productive having run national multi-center trials and having received multiple Patient-Centered Outcomes Research Institute (PCORI) grants; they have been awarded more than $30 million in research funding in the last seven years. The Department is heavily engaged in the education of medical students, residents, and fellows. The residency training program has 32 residents and is led by an experienced program director. Residents rotate on the following services: inpatient, child and adolescent, alcohol and drug recovery, consultation liaison, outpatient, community psychiatry, research, and specialty clinics such as neuropsychiatry and women’s mental health. The ABPN pass rate is above the national average and increasingly we have retained our graduates as Staff. This position represents an outstanding leadership opportunity where the ideal candidate will be a clinician-scientist recognized nationally for his/her experience and accomplishments in research, clinical care, teaching, and
administration. It will be paramount that the individual possesses the skills necessary to lead and grow a large and complex department with a multi-faceted mission and multiple stakeholders. The Chair will need to work closely and effectively with the directors of all disease-based Centers in the Neurological Institute, including the Center for Adult Behavioral Health, Center for Child & Adolescent Psychiatry, Alcohol and Drug Recovery Center, and the Center for Comprehensive Pain Recovery. Qualified candidates will be expected to demonstrate experience and strength in the following areas: A strong history of original and innovative research and extramural funding. A strong history of mentoring and promoting the professional growth of faculty. Record of success identifying philanthropic opportunities and cultivating key relationships to grow same Track record of positive interpersonal engagement across behavioral health professionals. Vision for ensuring balance across the missions of research, clinical practice, and teaching. Psychiatrist candidates must be board certified by the ABPN or equivalent. A faculty appointment commensurate with experience is available at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. Interested candidates should submit their cover letter, curriculum vitae, and a list of 3 references to: Bartolome Burguera, MD, PhDChair, Endocrinology and Metabolism InstituteChair, Search Committee for the Department Chair of Psychiatry & Psychology Attention: Beverly Skala, Search Committee Secretary: skalab@ccf.org.

**PENNSYLVANIA**

**Company:** Universal Health Services (1096872)
**Title:** Child & Adolescent Psychiatrist in Southeastern Pennsylvania
**Job ID:** 14220220
**URL:** [https://jobs.source.aacap.org/jobs/14220220](https://jobs.source.aacap.org/jobs/14220220)

**Job Description:** Foundations Behavioral Health in Doylestown is seeking a fellowship-trained child and adolescent psychiatrist. The new associate will join an experienced multidisciplinary team consisting of child & adolescent psychiatrists, pediatricians, nurse practitioners, psychologists, social workers, behavior therapists, occupational therapists, and speech therapists. This is an excellent opportunity for a new graduate or experienced psychiatrist. Foundations Behavioral Health offers an acute psychiatric hospitalization program as well as a residential facility specializing in the treatment of children, adolescents and young adults who are experiencing acute psychiatric disturbance with a diagnosis of autism spectrum disorder, intellectual disability, or other neurodiversities comorbid with either mood, thought, and/or behavioral disorders. Located in Southeastern Pennsylvania, the region offers a plethora of recreational activities allowing for a professional career and a fulfilling personal lifestyle while near Philadelphia, NYC, and beaches of New Jersey. We are proud to offer: Competitive compensation Highly rewarding bonus structure Malpractice insurance Paid Time Off Matching 401k CME Health insurance package Relocation Student loan assistance Employee stock purchase plan For consideration, please contact Stephanie Figueroa, In-house Physician Recruiter, Universal Health Services, at stephanie figueroa@uhsinc.com or (484) 695-9913. Candidates may also apply directly at [www.uhsinc.com/careers/physician-career-opportunities](http://www.uhsinc.com/careers/physician-career-opportunities).

**TENNESSEE**

**Company:** University of Tennessee Health Science Center (1235053)
**Title:** Assistant Professor/Child and Adolescent Psychiatrist
**Job ID:** 14283913
**URL:** [https://jobs.source.aacap.org/jobs/14283913](https://jobs.source.aacap.org/jobs/14283913)

**Job Description:** The Department of Psychiatry at UTHSC is a growing and thriving department that is actively recruiting faculty in several areas. The Department is highly collegial and has a strong commitment to diversity and inclusion. The University of Tennessee Health Science Center is the flagship statewide, public, academic health institution in Tennessee. Founded in 1911, the mission of the University of Tennessee Health Science Center is to improve the health and well-being of Tennesseans and the global community by fostering integrated, collaborative, and inclusive education, research, scientific discovery, clinical care, and public service. UTHSC is the largest educator of health care professionals in the state and operates the state’s largest residency and fellowship advanced training programs. Employing more than 4,600 people on its faculty, staff, and not-for-profit corporation faculty practice groups, and with more than 3,200 students across the state, UTHSC contributes $4 billion to the economy of Tennessee. The department encourages applications from all qualified applicants and celebrates diversity in age, class, ethnicity, gender, physical and mental abilities, race, sexual orientation, spiritual practice, and other human differences. Located in West Tennessee on the banks of the Mississippi River, Memphis is the second-largest city in the state and among the largest cities in the Southeast. The Greater Memphis
metropolitan area has more than 1.3 million residents, and the city ranks among those with the lowest cost of living in the country. It is home to a vibrant restaurant scene, a revitalized Downtown, the Midtown Arts District, many scenic neighborhoods, an active medical district, and a large influx of recent college graduates. Memphis boasts attractions, including Elvis Presley’s Graceland, the Memphis Grizzlies, historic Beale Street, the National Civil Rights Museum, the second-largest urban county park in the United States, and the Memphis in May World Championship Barbecue Cooking Contest. The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADAA/V institution in the provision of its education and employment programs and services. For more information, contact Ron Cowan, Chair, Department of Psychiatry at rcowan3@uthsc.edu.

Job Requirements:
Full medical license, completion of accredited Child and Adolescent Psychiatry Fellowship by time of employment.

VIRGINIA
Company: Inova Health System
(1167948)
Title: Medical Director- IP Adolescent Psychiatrist
Job ID: 14178916
URL: https://jobsource.aacap.org/jobs/14178916

Job Description:
Apply Now Save Job Block Job Share with a Friend Print Come join our Come join our growing Behavioral Health team and make each day impactful for our beautiful community! We are seeking an experienced Medical Director to join our Inpatient Services team. Inova Behavioral Health supports Inova’s overall mission, promoting total wellness – mind and body – by offering a full spectrum of mental health and addiction treatment services to the surrounding Northern Virginia and Washington, DC, metropolitan community. Our extensive continuum of care includes an urgent psychiatric and addiction assessment center (IPAC), inpatient psychiatry, inpatient detoxification, partial hospitalization programs (PHP), intensive outpatient programs (IOP), outpatient psychiatric appointments and outpatient counseling services. Inova Health System serves more than two million people each year throughout the region. Inova is consistently ranked among the top healthcare providers in the United States and is home to the Inova Children’s Hospital, Women’s Hospital, Heart and Vascular Institute, the Schar Cancer Institute, The Center for Personalized Health and Translational Medicine. Inova is shaping the future of health through the integrated network of hospitals, urgent care, primary and specialty care, and outpatient care that includes Behavioral Health. As a result of growth and expansion, Inova seeks Behavioral Health Physicians to diagnose and treat patients in the adult, child &adolescent services. As a behavioral health physician, you will develop and foster team partnerships, collaborate with case management and the multi-disciplinary team of healthcare providers. INOVA offers a generous compensation plan, salary and bonus, as well as a comprehensive benefits package that includes health, dental, vision, 401(k), 457(b), paid life, short-term, long-term insurances, paid malpractice insurance, license and DEA fees, and an association membership’s dues. Inova provides paid-time-off for CME and CME $ and much more.

Job Requirements:
Graduate school of medicine VA license, or able to obtain a VA License Board Certified 3-5 years of leadership experience

VIRGINIA
Company: Children’s Specialty Group
(1229096)
Title: Psychiatry and Psychology Medical Director Position
Job ID: 14166505
URL: https://jobsource.aacap.org/jobs/14166505

Job Description:
Children’s Hospital of the King’s Daughters (CHKD) and Children’s Specialty Group (CSG) are seeking several Child and Adolescent Psychiatrists to join our growing team. The future of the Child and Adolescent Psychiatry practice at CHKD includes a $224 million 60 bed mental health hospital, a 7-bed medical psychiatric inpatient unit, a 30-patient partial hospital program, and expanding our outpatient mental health services. The successful candidate will join a multi-disciplinary team providing family centered evidenced-based care to children. Eastern Virginia Medical School, which is co-located on our campus, is the academic home for our group. Our faculty hold joint appointments in the Departments of Psychiatry and Pediatrics, and they are active in educating medical students and residents. Additionally, our staff have opportunities to participate in scholarly projects and research. We are in coastal Virginia known for its beautiful beaches and with easy access to cultural and historical venues. Our clinical home at Virginia’s only freestanding children’s hospital and the newest child psychiatric facility in the nation, provides exciting and challenging career options for early, mid-career, and seasoned child psychiatrists. Highlights include: Partnership track opportunity in an academic setting, relocation reimbursement, generous CME, short and long-term disability, malpractice insurance, a robust retirement plan, profit-sharing, and health insurance. Interested candidates contact: Brittany Langley Brittany.langley@chkd.org, (757) 668-9686 office Visit our website: CSGDocs.com/Careers.

WEST VIRGINIA
Company: WVU Medicine (1231388)
Title: Child and Adolescent Psychiatrists
Job ID: 14156262
URL: https://jobsource.aacap.org/jobs/14156262

Job Description:
West Virginia University School of Medicine and the Department of Behavioral Medicine and Psychiatry are recruiting Child Psychiatrists in Morgantown, WV. Besides providing excellent patient care, you will also be actively involved in teaching medical students, residents, and fellows. Applicants must have an MD or DO degree or foreign equivalent and be eligible to obtain a West Virginia medical license. Candidates must be board certified / eligible in child psychiatry. The West Virginia University Rockefeller Neuroscience Institute, led by Dr. Ali Rezai, is expanding to include the clinical, research, and academic missions of Neurosurgery, Neurology, Neuroradiology, and Behavioral Medicine and Psychiatry. WVU Medicine Children’s is a regional referral center for pediatric subspecialties and provides faculty direct access to highly advanced technology and comprehensive ancillary pediatric services. The new 150 bed Children’s Hospital and Women’s Pavilion, scheduled to open in the summer of 2021, will have a full suite of pediatric operating rooms, pediatric imaging suite, and dedicated pediatric
anesthesia staff. The hospital will include 34 pediatric beds, 54 NICU beds, 31 PICU beds, Heart Institute, and a dedicated cancer center. WVU is a Level 2 Pediatric Trauma Center, with plans to become Level 1, as it is for adults currently. WVU Medicine is West Virginia University’s affiliated health system, West Virginia’s largest private employer, and a national leader in patient safety and quality. The WVU Health System is comprised of thirteen member hospitals and five hospitals under management agreements, anchored by its flagship hospital, J.W Ruby Memorial Hospital in Morgantown, a 700+ bed academic medical center that offers tertiary and quaternary care. WVU Medicine has more than 1,000 active medical staff members and 18,000 employees who serve hundreds of thousands of people each year from across the state of West Virginia and the nation. Morgantown, WV is located just over an hour south of Pittsburgh, PA, and three hours from Washington, DC and Baltimore, MD. Morgantown is consistently rated as one of the best small metropolitan areas in the country for both lifestyle and business climate. The area offers the cultural diversity and amenities of a large city in a safe, family-friendly environment. There is also an excellent school system and an abundance of beautiful homes and recreational activities. To learn more, visit https://medicine.hsc.wvu.edu/bmed/ and apply online at http://wvumedicine.org/careers/. For additional information, please contact Pam Furbee, Senior Physician Recruiter and Talent Advisor, at pamela.furbee@wvumedicine.org. West Virginia University & University Health Associates are an AA/EEO employer – Minority/Female/Disability/Veteran – and WVU is the recipient of an NSF ADVANCE award for gender equity.

WISCONSIN

Company: University of Wisconsin School of Medicine and Public Health Department of Psychiatry (1230652)
Title: Child and Adolescent Psychiatrist
Job ID: 14129986
URL: https://jobsource.aacap.org/jobs/14129986

Job Description:
The University of Wisconsin Department of Psychiatry in Madison, WI, is seeking two Board Certified/Board Eligible Child and Adolescent Psychiatrists to expand its clinical and academic programs. UW Health is the integrated health system of the University of Wisconsin-Madison School of Medicine and Public Health serving more than 600,000 patients each year in the Upper Midwest and beyond with 1,400 physicians and 16,500 staff at six hospitals and 80 outpatient sites. Madison is consistently recognized as one of the happiest and healthiest places to live and work in the US, having been ranked as one of the most beautiful, bike-friendly, and environmentally “green” cities in the country. Madison was also most recently named the third-best place to practice medicine in the US by Medscape. Position Details: A blend of clinical, teaching, and research activities based on candidate interest and skills. Primarily provide pediatric psychiatry care across outpatient and inpatient settings with some coverage of adult outpatient care. Responsibilities can include didactic and clinical teaching of fellows, residents, medical students, and other health care trainees. Supervision and mentorship of residents/fellows/trainees. Multi-disciplinary and collaborative team of physicians, nurses, mental health therapists, mental health associates, and social workers. Available positions on the non-tenure tracks at the assistant, associate, and full professor levels. Full or Part-Time (50-100%) positions available, with one call week approximately every 8 weeks. The University of Wisconsin provides a highly competitive compensation package and excellent benefits. Qualifications: Superb commitment to improving the lives of youth and families struggling from mental and behavioral health problems. Graduate of an accredited ACGME psychiatry residency and child/adolescent fellowship training program Board Certified or Board Eligible in Child and Adolescent Psychiatry Wisconsin Medical License obtained by start date Ability to obtain and/or maintain DEA certification for the State of Wisconsin At least one year of clinical experience in the treatment of psychiatric disorders preferred. Credentialled with UW Health managed care plans, credentialing, and staff privileges at UW Hospital, Unity Point Health Meriter Hospital, and VA Middleton by start date. The School of Medicine and Public Health has a deep and profound commitment to diversity. As such, we strongly encourage applications from candidates who foster and promote the values of diversity and inclusion. Please click here to learn more about this position and other available positions in our Department. To Apply: Please submit a letter of interest and CV to Pratik Prajapati, MHA, Director, Business Services (pprajapati@wisc.edu). The University of Wisconsin is an equal opportunity/affirmative action employer. Unless confidentiality is requested in writing, information regarding the applicants must be released upon request. Finalists cannot be guaranteed confidentiality. Please click here to learn more.
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BLACK HISTORY MONTH