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AACAP'S 62ND ANNUAL MEETING
OCTOBER 26–31, 2015 • SAN ANTONIO, TX
HENRY B. GONZALEZ CONVENTION CENTER & GRAND HYATT SAN ANTONIO

WITH THE SPECIAL PARTICIPATION OF
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Cover: HELP! We’ve combed through our files and can’t seem to find any information on the cover photo!? It’s a beautiful picture, and we need to properly credit the photographer. If you submitted the cover picture, or have any information related to the picture please contact rgrant@aacap.org.
MISSION STATEMENT

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

– Approved by AACAP Membership December 2014

FUNCTION AND ROLES OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

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

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

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

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

American Academy of Child & Adolescent Psychiatry
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MISSION OF AACAP NEWS

The mission of AACAP News includes:

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

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PRESIDENT’S MESSAGE

Join Me at AACAP’s Legislative Conference!

Paramjit T. Joshi, MD,
AACAP President

Dear Colleague:

Our 11th Annual Legislative Conference, (formerly known as Advocacy Day), sponsored by the American Association of Child & Adolescent Psychiatry (AACAP), is occurring in Washington, D.C. on April 23-24, 2015. I strongly urge you to attend. If you have not already done so, please register by visiting www.aacap.org/legislativeconference. You also can book a hotel room at the special AACAP rate of $225/night until Friday, April 3, 2015, at 5:00 pm ET.

AACAP’s Legislative Conference is an exciting opportunity to learn about how to become an effective advocate for our subspecialty and our patients, as you will partner with fellow members, trainees, families, and youth to promote child and adolescent psychiatry on Capitol Hill. Please note that 2.0 AMA PRA Category 1 Credits™ are available for the Special Legislative Advocacy Training and Question and Answer Session from 3-5 pm on Thursday, April 23. You MUST register for this special session to receive credit.

Now, more than ever, we must maintain a very sharp focus on key issues such as the need to address workforce shortages, advance comprehensive mental health reform legislation, and achieve Children’s Health Insurance Program (CHIP) re-appropriation. These are extremely important issues for all of us as child and adolescent psychiatrists and for America’s youth. They will only be addressed if we can impress upon our Senators and our Representatives that they must take action to improve mental health care in this country.

Our Washington-based Department of Government Affairs and Clinical Practice is there to answer any questions that you may have about this Legislative Conference. Please feel free to contact Zachary Kahan, Legislative Coordinator, at zkahan@aacap.org for more information.

Please register for the 2015 AACAP Legislative Conference and make your plans to attend. I look forward to seeing you all in Washington in April!

Very sincerely,

Paramjit T. Joshi

Our current schedule of events for the Legislative Conference is as follows:

**Thursday, April 23**
- 2:00 pm – 5:00 pm: Registration (Mayflower Renaissance)
- 2:00 pm – 3:00 pm: Resident, Newcomer, and Family Orientation (Mayflower Renaissance)
- 3:00 pm – 5:00 pm: Special Legislative Advocacy Training and Question and Answer Session (Mayflower Renaissance)
- 6:00 pm – 7:30 pm: Legislative Conference Congressional Reception (Mayflower Renaissance)

**Friday, April 24**
- 6:30 am – 7:00 am: Breakfast (Mayflower Renaissance)
- 7:00 am – 8:45 am: Legislative Advocacy Policy and Political Tutorial with special keynote speaker (Mayflower Renaissance)
- 9:00 am – 4:00 pm: Hill Visits (Capitol Hill)
- 4:00 pm – 5:00 pm: Legislative Advocacy Conference Debriefing (Mayflower Renaissance)

And on Saturday, April 25, the AACAP Assembly will meet.

The American Academy of Child and Adolescent Psychiatry is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The American Academy of Child and Adolescent Psychiatry designates this live activity for a maximum of 2.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Join other AACAP members, and family and youth advocates, on April 23-24, 2015, to promote child and adolescent psychiatry and children’s mental health issues on Capitol Hill.

During this event, you will join fellow members, residents, family members, and youth as you learn about the legislative process, develop relationships with legislators, and discuss the issues that most affect your patients and practice. The AACAP Department of Government Affairs will guide you on what to say and do during your meeting, and provide you with the advocacy materials to shape your message.

For more information visit: www.aacap.org/LegislativeConference or contact Zach Kahan, Legislative Coordinator, @ zkahan@aacap.org or 202-587-9669.
Psychotherapy is More than a Code — It Should be a Highly Value-based Reimbursement Even in an Integrated Health Care Setting

Mark S. Borer, MD

For many years Nathaniel Donson, MD, has chaired a Clinical Case Conference, “Contributions from Child Psychoanalysis,” at the AACAP annual meetings. At the 2014 Annual Meeting in San Diego, California, the Conference focused on “Medication Management with Psychodynamic Psychotherapy.” The cases of two children were presented by their analysts, and reviewed by other presenters at the Conference for the benefit of attendees.

What was impressive and different about this Conference was that instead of a focus on psychopharmacology preparing a child to benefit from psychotherapy, which is so often the approach when we prescribe, medication was sensitively considered and added as part of the treatment at pivotal points in psychotherapy that was already underway. In the context of unfolding psychotherapy, caring and devoted analysts helped the child with his or her development, and inner conflicts. The analysts worked with the child, and with family as available, to help resolve intrapsychic and interpersonal issues, preparing the proper timing and role for the medication, which was judiciously applied, to help the child toward the desired behavioral solutions to the presenting complaints. The sensitivity of the care delivery felt like the neurosurgical equivalent of delicately severing several pain-causing individual nerve fibers with a laser scalpel, as opposed to treating back pain with a spinal fusion.

At the annual meeting, this clinical presentation was juxtaposed with committee meetings and presentations on innovative care delivery and “how to work with Accountable Care Organizations (ACOs).” Could this era of innovation offer a re-entry of psychodynamic psychotherapy integrated with psychopharmacology in the treatment of children and adolescents? Could this be an era where finely tuned and integrated psychodynamic psychotherapy interventions may be delivered directly by the child and adolescent psychiatrist (CAP) or with the help of CAP clinical consultation by other members of the integrated mental health team? Or might there even be medical professionals on an integrated team better informed of some of the developmental psychodynamics of the children with whom they are working?

“Could this era of innovation offer a re-entry of psychodynamic psychotherapy integrated with psychopharmacology in the treatment of children and adolescents?”

Integrated models allow access to the psychiatrist, not only for direct assessment and follow up, but also for billing of the medical component of the service using an evaluation and management code (like other physicians do). Could integrated models also allow child and adolescent psychiatrists to integrate psychopharmacological treatments into the fabric of psychodynamic psychotherapy? There are add-on psychotherapy codes that may be used as cost-effective, add-on codes. In most cases, use of the combined codes may reimburse our services better than the reimbursements under traditional managed care. Under traditional managed care, outpatient visits with combined medication visits and psychotherapy for children were often paid for at almost the same rate as the medication visit alone, a real disincentive to doing therapy. Although the evaluation and management code may pay better for time spent than the add-on psychotherapy code, if one considers the overall combination as a cost effective and valuable intervention, as portrayed in this psychotherapy symposium, then we are still doing better than before. And if we can show better outcomes for combined delivery of our therapy skills with our pharmacology skills, or vice versa, then ACOs will reward us better under plans which reward value-based reimbursement.

Some additional areas for reimbursement consideration under innovative and ACO models, which were usually not reimbursed under traditional managed care, include telemedicine interventions, which have been shown to be widely accepted by patients, including children. There is also access to professional-to-professional primary care consultation, in which the patient is not seen face-to-face, but where the primary care portion of the integrated team is informed regarding appropriate diagnosis, screening tools, developmentally appropriate interventions, medication recommendations, and best therapy models for the particular acute or chronic, mainly psychiatrically ill or mainly medically ill, patient. These opportunities for discussion, case presentation, and collaboration would allow some of those wonderful psychoanalytic presenters from the Annual Meeting Clinical Case Conference, as well as other child and adolescent psychiatrists among us, to reach out to our mental health and medical team colleagues.

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Psychotherapy is More than a Code continued from page 71

and remind them about such important concepts as transference and countertransference, projective identification in borderline personality patients, positive and traumatic introjects in posttraumatic stress syndrome (PTSD), projection in psychotic children, displacement in bully victims who become bullies, and a host of other psychodynamic issues. These issues, when understood, would be like the shortcuts from our computer desktops, which take us right to areas to be addressed, where resolution of developmental arrests and healing of hurts can occur—right in the patient centered medical home or by direct reference out in the child’s home, school, or neighborhood of care.

If we can use the CPT psychotherapy add-on codes and the policy push toward ACOs and innovative care models in this way, a core skill set for CAPs would be reinforced—not only in an annual meeting case conference, but in the daily outpatient work and primary care consultation to the integrated health care teams we are forming with integrated care programs and ACOs.

Dr. Borer is vice chair of the AACAP Assembly of Regional Organizations. He is in private practice at Psychiatric Access for Central Delaware, P.A. in Dover, Delaware. He may be reached at bugglinborer@comcast.net.

Reporting Psychotherapy with Medical Evaluation and Management (E/M)

Benjamin Shain, MD, PhD, and the AACAP CPT Coding Subcommittee

Psychotherapy and medical evaluation and management (E/M) services performed on the same day by the same provider may be reported with an E/M code and a psychotherapy add-on code. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. This sounds challenging as these services are commonly intertwined in time and content throughout a session: medical data affects choice of psychotherapeutic intervention and data from therapeutic communication may be part of the history and mental status exam. Nonetheless, for coding purposes, the medical and psychotherapeutic components may be separately identified as follows:

- Select the E/M code first based on key components (history, or examination, and medical decision making). For this purpose, time may not be used as a basis for selecting the E/M code.
- Select the psychotherapy add-on code based on psychotherapy time in addition to time spent on activities used to meet criteria for the E/M code. The add-on code is the one closest to the actual time, i.e., 90833 (30 minutes) for 16-37 minutes, 90836 (45 minutes) for 38-52 minutes, and 90838 (60 minutes) for 53 minutes or greater.

If the psychotherapy session involves “interactive complexity,” code 90785,* you may report 3 codes for that single visit: E/M, add-on psychotherapy, and add-on interactive complexity.

Additional CPT coding information may be found on the AACAP website (http://www.aacap.org/) by selecting “Member Resources” and then “CPT and Reimbursement.”


Share Your Photo Talents With AACAP News

The Editorial Board of AACAP News is soliciting photographs from AACAP members to be published on its front page, inside standing alone, or accompanying relevant articles or stories. The published photographs should—in some artistic way—illustrate themes pertaining to children, childhood, parents and children, parenting, or families. All AACAP members are invited to submit up to two photographs every two months for consideration.

If you would like your photo(s) considered, please send a high-resolution version to Dr. Rosenfeld, the AACAP News photo editor, at ARosen45@aol.com. Please include a description, 50 words or less, of the photo and the circumstances it illustrates.
CLINICAL VIGNETTE

“Almost Having Fun as Confusing Metaphors Get Out of Hand”

Have you figured anything out so far?”

“One night I had plans, but they weren’t solid. Actually, they were bad plans. I knew of a party, but didn’t know where it was or when it was. I was all stressed about what to do. My mom said I should go. I didn’t want to, but then I felt horrible that I was letting myself down. I got into a funk and cried a lot and felt terrible. It was like I was in a hole.”

“This was recently?” I asked.

“Yes.”

“And did you go?”

“No, and I felt terrible the rest of the night. In the morning, I felt better.”

“And how did that feel?”

“It scared me. I felt that I could be sucked back in a hole and be there forever. I have gained some insight into sadness. I feel bad for others who can’t see how bad everything can be. I now see how everything leads back to the sadness. Others are ignorant to the reality of the world and its horribleness. They feel horrible and lonely, like I do. I’m still afraid. When I’m depressed, I feel awful, but I feel I have a power, but it’s not a good power. I forget how bad I feel. My feelings are confusing. I’m feeling bad now, but in a different way. I feel awful, but it’s a different bad.”

“And do you prefer one over the other?” I questioned.

“I prefer going out. When I’m in my bedroom, it’s like being continually in a bathtub, all pruned up. Now I feel I can get out of the bathtub and have friends, but when I’m out, I still have problems. I’ll be happy at first and then I’ll fall into the deep end of a pool and feel helpless and sad. I am able to climb out and am okay, but I am then afraid I may fall into another pool.”

“I think less need to go back to the bathtub?” I asked.

“Yes. Falling into the pools is a different bad. It’s shorter. It’s a different type of evil. I don’t want to go back to my bedroom. I’m scared. When I’m in the pool, it’s simple. It’s me and the water and I’m drowning. It’s painful, but I feel clarity. It’s simple, but it isn’t simple. I can think of how bad things are and then I’m not in pain from drowning.”

As we were nearing the end of the session, I summarized that it seemed that she had switched one set of problems for a better set, which was still scary, but which she preferred.

“There are usually monsters out there when I’m out with my friends. I don’t know what they are. I can’t see what they are until I’m up close to them and then I know what I’m dealing with.”

I added, “Like the horror pictures in which they never clearly show you the monster in the beginning of the movie.”

“Yes,” she said with a smile. “It’s like watching the movie and being scared, but things are better a day later. When I watch a horror movie at night, it’s hard for me to go to sleep due to the possibility that the monster exists. In the movie, there are ‘jump scares.’ You know there’s a monster out there which you haven’t seen. You can know it’s not real, but it’s still scary.”

She then paused and smiled. “You know that these metaphors are getting out of hand.”

“They can get confusing at times,” I responded with a smile back at her.

“I feel out of control,” said Jackie. “At times, I don’t know if the monsters are real and will attack me. It’s confusing.

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Sometimes I’m not quite sure about the monsters, even the next day.”

As she said this, I was confused as to where she was with her out of hand metaphor. I was not sure how much insight and distance she actually had from her fears. As the session continued, I had become more and more intrigued by her earlier remark that she knew things that others didn’t. It seemed important. I wanted to know more about it!

“So you sometimes feel you have insights that others don’t have?” I asked.

“Yes,” she responded. “An insight that they are ignorant of.”

“Does that make you unique?” I asked.

“Yes, there is a comfort to it, especially when things are clear. When I’m in those moods, I know. When depressed, I see the monsters clearly. When not depressed, I can see ghosts in the distance that I usually can’t see clearly.”

“Is it that the depression seems to focus you and at times is preferable to being anxious about how scary the future seems?” I queried.

“Yes,” she replied.

“So being in your room is reinforcing in a way and less scary than going out? Is that why you stayed in your room so much?” I questioned.

“I’m not sure... maybe.”

After a long, uncomfortable pause, I shared an association that I had in response to our discussion: “I find myself associating to suicidal people who become calm when they decide to kill themselves. They feel things are clear and they feel at peace. They feel they have a solution.”

In response, she repeated that, although scary, she preferred the short falls into pools to the long pruny baths. “But the pools are still scary,” she highlighted.

“Well then, we need to focus on trying to better understand the scary pools in therapy.”

She nodded in agreement and continued, “When I’m out of my bedroom, I’ll have a negative thought and then I’ll have a flood of negative thoughts that drown me.”

“Like in the horror movies when you enter a cave and then you are suddenly surrounded by millions of bats?” I asked.

“That’s how it feels!” she replied with a smile. “And it happens that quickly.”

“We should talk more about the negative thoughts that fly around your head and don’t actually hurt you and the ‘pools’ of feelings that drive you batty.”

She nodded in agreement.

As she left, she told me about a Halloween party that she was going to with her friends.

“Have a scary good time!”

“I will,” she said with a smile. ■

Dr. Drell is past president of AACAP and head of the Division of Infant, Child, and Adolescent Psychiatry at the Louisiana State University Medical School in New Orleans, Louisiana. Dr. Drell may be reached at MDrell@lsuhsc.edu.

Clinical Vignette continued from page 73
HISTORY AND ARCHIVES COMMITTEE

And the Academy said, “Let there be an opera, and, behold, there was an opera!”

David W. Cline, MD, Co-Chair
History and Archives Committee

It all began at the 1993 AACAP Annual Meeting in San Antonio, Texas, where the newly formed History and Archives Committee sponsored a symposium, “Fifty Years After World War II: Hidden Jewish Children of the Holocaust.” Four speakers told their remarkable story of survival during that terrible conflagration and what had become of them thereafter. Yehuda Nir, MD, a child and adolescent psychiatrist from New York City, brought the audience to tears as he quoted from his book Lost Childhood.

The next year, at the 1994 Annual Meeting in New York City, the Committee sponsored another symposium, “Childhood Trauma Fifty Years Later; How World War II German-Born Children Struggle With Their Past.” Gottfried Wagner, great-grandson of Richard Wagner, described his exposure of growing up in a famous family, many of whom were Nazi sympathizers.

At the Annual Meeting in Philadelphia in 1996, a finale of the triptych symposia was presented, “Childhood Trauma Fifty Years Later: How World War II Jewish and German-Born Children Struggle with Their Past and Each Other.” Yehuda Nir and Gottfried Wagner discussed their experiences in a dialog between one German and one Jew’s attempt at understanding each other as human beings.

“Yes, it is true. Our Academy has nurtured the creation of an opera!”

It was at this meeting that the idea of an opera about their dialog was discussed with Jan Hamer, composer, and Mary Azrael, librettist. The opera Lost Childhood was conceived and given birth. Over the course of the next 18 years and much work, the opera was composed and finally presented in complete concert forum at the Strathmore Theater in Bethesda, Maryland, to a full house of 2,000 on November 9, 2013, seventy-five years after Kristal Nacht, 1938. It received a standing ovation and good reviews.

And, behold, there was an opera! Virginia and James Anthony, MD, had us over to their home for formal tea to celebrate that event.

The AACAP and the History and Archives Committee take pleasure in having played a role in this accomplishment. Bezonnenheit!

Our history is not only revealing and inspiring but, as Jackie Kennedy has pointed out, “If we do not know our past, then we cannot have a future.”

Author’s Note: Joseph Noshpitz, MD, wrote a history of the Academy, tracing our beginning, starting with the first decade of the 20th century up to the 1980s. He described the state of our society, the role of general psychiatry, and the origin of child and adolescent psychiatry. He put it in the context of what was going on in our country and the world decade by decade. Hitherto fore, it has not been published, but when final editing is complete, it will appear on the AACAP website.

Dr. Cline is adjunct professor, Department of Psychiatry, University of Minnesota Medical School and co-chair of the AACAP History Committee. He may be reached at davidwcline@comcast.net.
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**NATIONAL CHILDREN’S MENTAL HEALTH AWARENESS DAY**

**MAY 7, 2015**

[www.samhsa.gov/children](http://www.samhsa.gov/children)
The summer of 2014 marked a 412 percent fiscal year increase in the number of immigrant families entering the United States without documentation (U.S. Customs and Border Protection 2014). A growing percentage of these individuals were women and children from Guatemala, El Salvador, and Honduras reported to be fleeing gangs, political persecution, and domestic violence. Reflecting this rapid influx, the number of immigration detention center beds increased from 90 to approximately 3,600 within a span of six months. These beds have been spread over Artesia, New Mexico; Karnes City, Texas; Berks County, Pennsylvania; and Dilley, Texas. Dilley’s detention center is by far the largest of the group, amassing 2,400 beds (Min Kim 2014).

Under American asylum law, an adult detainee can be granted asylum if there is a proof of violent abuse in his/her country of origin without protection from police. However, in the wake of the recent aforementioned increases in refugee numbers, allegations have been made that the U.S. Department of Homeland Security’s Division of Immigration and Customs Enforcement has been deporting detained women and children without a proper hearing under “expedited removal.” Even those who are not immediately deported face several barriers to seeking legal asylum status: detainees are not entitled to government-sponsored legal representation, little information is available to detainees to help them navigate the legal system or inform them of their rights, and the remote locations of the detention centers make it difficult to obtain access to legal representation or family support (Preston 2014).

As a witness to these legal injustices, one volunteer lawyer noted to reporters in Texas, “[The detainees] are kept two or three days in custody at the border and processed under difficult, cramped conditions….A client told me that she was held for several hours in a room with several other women and children. They called her in at 3:00 a.m. and told her to sign the (expedited removal) papers. She told me she was so tired and confused that she had no idea what she was signing” (Del Bosque 2014). By August 2014, the American Civil Liberties Union, American Immigration Council, National Immigration Project of the National Lawyers Guild, and National Immigration Law Center filed a suit against the U.S. Department of Homeland Security on behalf of several families for perceived civil rights violations in this deportation process (Preston 2014).

At the Artesia Center in a remote area 200 miles from the US-Mexico border, more than 300 women and children were initially deported in the months after opening, with only 37.8 percent of detainees reported to be passing their initial interviews to allow for having their cases heard compared to the 62.7 percent national average. Bonds reportedly were set as high as $30,000 (The Guardian 2014). In response to these concerns, a rotating system of pro-bono lawyers began volunteering to help the hundreds of remaining women and children make their cases (Preston 2014). Several of the volunteers have spoken out about the quality of the facility’s infrastructure, including the lack of transparency in healthcare practices and the geographic and social isolation. They told of women being asked to retell graphic details of their trauma with no privacy and in front of their children, vicarious trauma reported by lawyers and responders, and one case of a child reported to have been raped while in custody (Del Bosque 2014).

While immigration itself is a hotly contested political issue with both recent pro- and anti-immigration protests placing pressure on government action, providing basic services to children and addressing unmet mental health needs is a separate humanitarian issue. Underscored by the above reported conditions, these detention centers are clearly not environments in which

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children can thrive. In these containment areas, crowded with traumatized strangers, babies cannot experience a sense of safety and protection, which allows for trust and exploration; latency age children separated from family members, school, peers, and community internalize an identity of being “illegal,” “alien,” a wrong doer; and teenagers are unable to test their independence, consolidate their individual identity, and learn intimacy and life skills. Family detention centers, the solution chosen by our government to deal with asylum-seeking children and families from Central America, are failing to respond to these important developmental needs.

As physicians sworn to the Hippocratic Oath, which does not discriminate against patients based on nationality or ethnicity and promises to honor “special obligations to ALL [our] fellow human beings” (Lasagna L 2014), we have an ethical and moral obligation to advocate for appropriate care to all people currently residing within our borders. As child and adolescent psychiatrists with a deeper understanding of the impact of trauma, this responsibility is still greater. AACAP has historically been at the forefront of local and national healthcare policy efforts. Recently, members of AACAP were instrumental in writing Amicus Briefs to the United States Supreme Court on a number of juvenile justice cases, which were cited by the Justices in their rulings in favor of our patients and their families (Baath et al. 2013).

The Fifth and Fourteenth Amendments of the United States Constitution guarantee due process rights and equal protection of the law to all people, citizen or not, being tried within the confines of the United States (Cornell 2014). As mentioned previously, significant concerns have been raised regarding whether the rights of families in detention are being respected by customs officials, and whether detainees have been/are being deported without a fair trial or appropriate medical treatment. The timing could not be any more crucial for AACAP to work with the American Academy of Pediatrics, the American Psychiatric Association, and potentially other medical organizations in developing a policy statement on the treatment of detained refugees in this country. Several AACAP Committees, including Diversity and Culture, Rights and Legal Matters, Juvenile Justice Reform, and International Relations, are in full support of a position statement being submitted to the AACAP Executive Council for approval. Such a statement advocating for solutions other than detention or deportation, and focusing on developmental and mental health needs of the detainees, could make a significant difference to this severely traumatized and marginalized population.

**This article is sponsored by the New Mexico Chapter of Child and Adolescent Psychiatry.**

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### References


www.law.cornell.edu/wex/alien


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Mid-childhood Maternal Depression has Strong Effects on Later Risky Behaviors

Maternal depression has been associated with all kinds of difficulties for adolescents, some of which may relate to a genetic predisposition to mood disorders, and some of which likely relate to depressed mothers not being able to emotionally engage with their children as well as if they were not depressed. Adolescents with depressed mothers engage in higher rates of risk behaviors such as substance use. While these findings are not particularly surprising, past research has not done much to explore this question longitudinally.

To try to add the longitudinal view of the effects of maternal depression, Wickham et al. examined the relationship between maternal depressive symptoms throughout nearly 3,000 children’s lives (from age 4-15 years) and their engagement in health risk behavior at age 16-17. The mother-youth pairs were pulled from a large prospective Canadian cohort. For analysis, the children were divided into several categories based on when their mothers had been depressed across their lives and severity of those symptoms.

While severity and greater exposure to maternal depression, as expected, predicted more difficulties later on, the most surprising finding from this study seemed to be that exposure to maternal depression between ages 6 and 10 appear to have the strongest effects on engagement in substance use (alcohol, cigarettes, and marijuana) and violent and nonviolent delinquent behavior at ages 16-17. More exposure to maternal depression during later adolescence did not seem to have nearly as much of an effect.

Some of this increase may come from the fact that adolescents with mothers who were depressed during their middle childhood appear to have earlier debut of such problem behaviors. Maternal depression exposes children to maladaptive maternal affect and behaviors as well as environmental stresses associated with maternal depression. Important emotion regulation skills are being developed during middle childhood, and exposure to maternal depression may lead to lasting developmental deficits that predispose to future risky behaviors.

Vitamin Supplement Shows Some Preliminary Benefit for ADHD (in adults, at least)

The use of complementary and alternative medicine (CAM) for many medical conditions, not excluding psychiatric conditions, continue to proliferate as patients seek care either in lieu of or in addition to more established treatment modalities. Many investigations of CAM focus on aspects of nutrition. In ADHD, much of these studies have focused on the effects of processed foods, elimination diets, food dyes, essential fatty acids, and early malnutrition. These studies have generally not shown robust, reproducible positive results. However, a few studies of micronutrient combinations have shown some positive results, but these have not been blinded studies.

Researchers at the University of Canterbury in New Zealand conducted a double-blind placebo-controlled trial of adults with ADHD randomized to either a micronutrient supplement (n=42) or placebo (n=38) for 8 weeks. The subjects had been medication free for at least 4 weeks. The micronutrient supplement in question was a formulation known as EMPowerplus™. According to its listing on Amazon.com and the product website (www.healthybraing6.com), the supplement is a “natural, holistic alternative to treating mood disorders such as ADHD, Bi-Polar [sic], Anxiety and Depression.” A 30-day supply appears to retail for around $50-60.

Active treatment was associated with improvements on self and observer (but not clinician) ADHD rating scales, while clinicians did rate those receiving active treatment as doing better than those on placebo both globally and with regards to ADHD symptoms. Patients with moderate to severe depressive symptoms at baseline who received active treatment had a greater improvement of mood symptoms as well. There were no significant adverse effects. Effect sizes were in the medium range (0.46 to 0.67).

While this is a pilot study, and a thorough review of the results is outside the scope of the News Updates, the effect sizes found with the use of the supplement along with the low rate of adverse effects will hopefully inspire further research that can clarify the benefits of such an approach in adults and then perhaps in children.

Perhaps frustratingly, the authors of the study avoid the inevitable question of which parts of the vitamin supplement show benefit. The authors argue that the “multi-ingredient approach challenges conventional understanding in that medical treatments tend to manipulate one variable at a time... (which is) at odds with human physiology as optimal functioning requires the presence of all nutrients in balance rather than one nutrient provided in high doses.” Whether this explanation satisfies the reader will vary.

Sleep and Screens Don't Mix

While the hallmark of the current generation of children and adolescents may be the extent to which they are expected to do more than one thing at once, there are some activities that do not lend themselves well to multitasking. It turns out that it is actually really hard to sleep and play on a smartphone at the same time. As inherently obvious as that fact may be, most pediatricians and child and adolescent psychiatrists cannot count how many times they have had that exact discussion with parents and their children. To be fair, playing on a smartphone might not be so attractive if all their friends were not doing it, too.

The effects of televisions on sleep hygiene have been well studied, but the rise of late night smartphone use has not yet received the same focus in the literature. Unlike televisions, smartphones are interactive, blinking notifications of activities begging for engagement with either software or other humans. Smartphones fit under the covers well and do not need to be plugged in at any given time to function. Smartphones fit in a pocket and live with us most of the day, while most of us are used to being away from a television for good chunks of time.

To expand our knowledge of the conflict between screens and sleep, Falbe et al. examined associations of different screens in sleep environments with sleep duration and perceived sufficiency of sleep. They obtained cross-sectional data from 2,048 fourth and seventh graders from the Massachusetts Childhood Obesity Research Demonstration Study in 2012 and 2013. Children who slept near a small screen (57% of the sample) reported sleeping about 20 minutes less each night and were 40% more likely to feel like they did not get enough rest the night before. Children who slept in a room with a television (75%) slept about 18 fewer minutes than peers who did not, though the presence of the TV did not obviously affect the perception of adequate rest. Both small-screen and television sleepers went to bed about a half-hour later than their screenless peers. The effects were a bit more prominent for the seventh graders compared to the fourth graders.

The authors speculate a variety of mechanisms that may be at play beyond the simple multitasking problem (if you’re playing on your phone, you aren’t asleep). Exposure to bright light may be interfering with circadian rhythm. Exciting movies or conversations with friends may lead to arousal that interferes with settling down for sleep. Watching more TV is also associated with drinking more heavily advertised caffeinated drinks, which does not help sleep either. The study is not set up to provide causal inferences, but mechanisms aside, advising families to keep screens out of the bedroom appears to be a safer bet for better sleep and all the positives that go along with it.


Adolescents with Mental Illness Just as Likely to Have Access to Guns as Their Peers

Without touching on the colorful politics of gun ownership in the United States, having access to a firearm in the home is an independent risk factor for death by suicide for adolescents. Restricting means to the most lethal methods of suicide lowers risks for death by suicide. Suicide is the second leading cause of death among adolescents. The AACAP Facts for Families #37 on “Children and Firearms” acknowledges that 1) we cannot gun-proof our children and adolescents, and 2) the best way to protect children against gun violence is to remove all guns from the home. AACAP and the American Academy of Pediatrics also advocate talking with families about safe storage practices, especially where adolescents are at higher risk for suicide, as safe storage practices do appear to somewhat mitigate the risk of having firearms in the home. Given that counselling about gun removal or safe storage is standard of care for treating adolescents with mental illness, we might reasonably expect that adolescents with mental illness would have less in-home access to firearms.

Researchers recently examined data from the cross-sectional National Comorbidity Survey-Adolescent Supplement, a nationally representative survey of over ten thousand adolescents aged 13-18 between 2001 and 2004. They used the large data set to estimate the prevalence of self-reported access to firearms, quantify the prevalence of mental illness and suicidality among adolescents living with a firearm in the home, and compared that to firearm access to adolescents without specific mental health risk factors for suicide.

Overall, about one-third of the adolescents reported living in a house with a firearm. About 40% of those adolescents said they had easy access to the firearm and knew how to fire it. Being a little older, male, white, and living in a higher-income household, and in a rural area were all associated with having a firearm in the home. Adolescents with access to firearms were about three times more likely to have alcohol abuse and drug abuse compared to those without.

Surprisingly, adolescents with a history of mental illness and/or suicidality were just as likely as their peers without mental illness or suicidality to report easy access to firearms in the home.

According to this research, whatever we are doing to counsel our patients and families about gun removal and/or safe storage (the latter of which may be much more politically palatable and still quite valuable in reducing risk of harm) does not seem to be working very well. That may be because we are just not doing a good job educating our families about the risks of guns in the home. That may be because of failed national policies and an acerbic public debate about the role of firearms in a polite society. That may be because adolescents with mental illness who have guns in their homes are not showing up in our offices enough for us to make a difference. Or, since these data are ten years old, maybe we were doing a bad job then and a better job now.

Regardless, restricting an adolescent’s access to firearms, either by removal from the home or by using less-controversial safe storage methods, is a proven means of reducing risk of death by suicide, and we need to do a better job of counselling our patients and families.

The Impact of Terror Attacks on Families

Pakistanis have been grieving the national tragedy and loss after the Peshawar attacks in various ways. Under normal circumstances, any community has a sense of safety, certainty, and predictability. Children go to school and return in the afternoon as predictably as the sun rises in the morning and sets in the evening. Violence shatters that sense of safety. Natural disasters such as earthquakes are certainly traumatic but man made violence hits communities in a different, much deeper way. Although no one is completely immune to the impact of trauma, some people are particularly vulnerable. As a native Pakistani living in the United States but with family in my home country, I try to balance my own grief with my responsibility to my own child and my family. Simultaneously, I have been examining my role as a child and adolescent psychiatrist in guiding families experiencing similar grief over recent and continuing international terror attacks. For AACAP members working with multicultural families, understanding your patients’ possible grief and propensity to be traumatized is critical.

To recover at an individual, family, and community level, we child and adolescent psychiatrists must take active measures while working to avoid major mistakes. Our foremost responsibility is—whenever possible—to restore the community’s sense of safety. Living in a prolonged state of terror and fear impedes healing.

Being overexposed to media complicates the traumatic response. In this age of relentlessly streaming media, repeated images of blood and flesh strewn everywhere, or of hangings and shootings, are likely to needlessly frighten millions of children and interfere with restoring their sense of being safe. Escaping this deluge of images frequently means that families need to choose between re-traumatization and disconnecting entirely from social media. In recent years, the media frenzy that feeds on disaster has escalated. Ideally, media organizations would consider this in their broadcasting policies; to date, they have not. Until they do, parents need to monitor children’s media use and mental health professionals have to guide families in limiting media usage. As child and adolescent psychiatrists, we can try to influence the standards at a policy level as we continue to work at the individual and family level to support recovery.

When we successfully restore the sense of safety, we next need to promote calmness and comfort. Everyone tries to make sense of events by talking about them. When not informed of the details of a disaster, our minds often fill in the blanks with the worst possible scenarios. Children, being more sensitive, often interpret their parents’ silence on traumatic events as meaning they need to be vigilant to an ongoing threat. Many caring adults are afraid to talk to their children about these violent episodes because they do not want to re-traumatize them; in reality, a rational voice from a loved one can answer their most basic questions. Children heal more fully when they can share their fears and concerns with their caregivers.

What can we child and adolescent psychiatrists do? We can guide parents to start the conversations with what their children already know and the concerns they have, encouraging them to speak at their child’s developmental age. Remind them that children younger than five often do not comprehend death fully and believe people return back after dying.

Between five and nine, children gradually begin to grasp the concept of death. For affected families, these conversations can be particularly challenging because children may ask repeatedly when their family member is coming home.

Remember that looking at a family will not give you information about what has been important to their community and culture. A recent tragedy that seems remote in the United States may be acutely affecting your patients. As we sit with families, listening and intending to help, what symptoms might we see? Children can experience numbness, difficulty sleeping, nightmares, avoidance of any reminders, and an inability to stop thinking about what happened, even if they have only experienced stories of the event. Trauma can also present as high emotionality, aggressiveness, or crying more easily. A report of new clinginess, school refusal, bedwetting, or conduct issues may trace back to a particular community’s experience of recent events. Parents may be advised to loosen their discipline policy temporarily as children might act out feelings in various ways. For instance, clinging might signal a need to feel more secure.

As providers, we can also encourage connectedness. At times like this, individuals need to connect closer as families, communities, and, on a larger scale, as one nation. Ask questions about how these events are affecting families.
Do not assume you know if families are affected by tragedies overseas. Familiarize yourself with the culture of your patients. If appropriate for the family, it may be helpful to encourage praying for the victims and their families.

Finally, we can promote self-empowerment whereby individuals learn about the resources available for continued health and return back to the routine activities. Encourage families to reach out to each other and provide them with tools and resources available such as the AACAP Facts for Families on “Helping Children After a Disaster” and on “Posttraumatic Stress Disorder.” More information is also available at the National Child Traumatic Stress Network (www.nctsn.org) or by downloading the smartphone app Psychological First Aid - PFA designed by the University of Minnesota.

I wish, as a Pakistani and a child and adolescent psychiatrist, I could tell you how well I am taking care of myself and my family but I do not know if I have properly processed this tragedy as of yet. The horrible stories I heard and the videos of violence (as aftermath of attack) I saw still bother me. I went to mosque to pray for the families. I have been talking to my family back home more often. I listen to my nephews and nieces talking about that incident. I asked my siblings never to view violent news media, even when kids are just playing in the same room. I wish I was able to go for at least a few weeks and support the families in Peshawar personally, but visa issues are not feasible at this time. I am doing my best. In being a care provider during a time of political unrest, I hope this article has also encouraged you to do yours.

Dr. Majeed is a current fellow at Brown University in Child and Adolescent Psychiatry. His interests include trauma, normal development, parenting, and medical education. He can be reached at smajeed@lifespan.org.

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Conversations With Hecklers

Justine Larson, MD, MPH, MHS

A member of the audience suddenly spat out, “I am so sick of psychiatrists.” An angular, dark-haired woman was sitting towards the middle of the old-fashioned lecture hall, with seats at desks sloping upward. I, the speaker, at the bottom – like a fish in a bowl. The woman was professionally dressed – in a cashmere-like navy blue pullover. Her hair was long and tightly pulled back.

My first heckler.

I had tweaked my standard attention deficit/hyperactivity disorder (ADHD) lecture specifically for this audience at a state hospital facility for seriously mentally ill adults – adding some information about diagnosing adults, ADHD with comorbid substance use disorders, etc. The psychiatrist who invited me had asked me to talk about something “they didn’t know a lot about” – so he thought a basic talk on ADHD would be of interest to this audience of therapists, students, and psychiatrists.

Initially, I tried to engage my heckler. I asked her to elaborate on her concerns. She complained about the criteria’s lack of specificity – and that the set of symptoms could have many causes. I acknowledged some of the challenges of DSM – that it is a list of symptoms and signs – not addressing etiology generally.

My response did not seem to satisfy her – I pressed on and moved into treatment. Again, my heckler continued to mumble to others around her, roll her eyes, and bark out comments. During the stimulant part of the talk – she yelled out, “They gave stimulants to fighter pilots during the war and they performed better, so what? It doesn’t mean we should be giving them to children.” The crux of her concerns seemed to be around her belief in the over-diagnosis of, and over-prescribing for, ADHD.

Other members of the audience were shifting in the their seats. They seemed intimidated by her, and uncomfortable. At one point, one of the men in the audience said meekly, “Will you let her give the rest of her talk?”

I found myself becoming increasingly flustered and started to sweat. I was in mid-sentence and my mind went blank as I imagined myself getting teary in front of the entire audience. I set a new goal for myself: to finish the talk without crying in front of the audience and get out of there.

I staggered through the remainder of the talk – diagnosis, treatment, special issues – and bumbled my way to the car. I slammed the door and essentially wept my way back the 2.5 hours north. Having some distance has allowed me to consider how my heckler pushed such a button. As a child and adolescent psychiatrist, my core sense of identity has to do with being a child advocate. To feel that a person who sees herself as advocating for children needs to fight me hits home because it calls into question my core identity as a professional.

Last year at a professional psychiatry conference, the scientologists were gathered near the conference center. I wandered over – curious to see the materials they were handing out. I locked eyes with one of the men in the picket line. His eyebrows were bushy and gray. I knew he felt righteous standing there in a picket line in front of a conference center where he knew doctors who “drug kids” were. Individuals like this man may see themselves acting as “child advocates.”

What is the best way to handle a heckler? A study from 1976 randomized an audience heckling situation to three different groups – one in which the speaker did not respond to a heckler, one in which the speaker responded in an upset manner, and then another in which he/she responded in a calm and relevant manner. The “heckles” were standardized at specific points throughout the talk. After the speech, audience members completed a Likert-scale survey in which they were asked about the speaker’s persuasiveness on the subject. In this study, the speaker responding to the heckler in a calm, relevant manner actually enhanced his/her persuasiveness (Petty and Brock 1976).

The world of stand-up comedy has also extensively addressed the role of hecklers and how to respond to them. Comics are advised to think about where they are most vulnerable – “a receding hairline, big nose, gappy teeth” (Comedy Courses 2011). Indeed, our field has its
own version of gappy teeth – historical moments of parent-blaming; lack of consistency in diagnosing specific disorders; the use of medications without consistently abiding by best practices for screening; prescribing that is far outside standard practice; and excessive polypharmacy, to name a few.

The fact that heckling often targets the most salient vulnerabilities allows for these vulnerabilities to be better identified and examined. Heckling of psychiatrists, and specifically child and adolescent psychiatrists, often originates from concerns about lack of diagnostic specificity, overprescribing of medication, and complaints about “pathologizing” individual differences. Our field should boldly examine these complex issues first and most voraciously. We can learn from Jerry Seinfeld, who has referred to himself as a “Heckle Therapist,” “…when people would say something nasty, I would immediately become very sympathetic to them and try to help them with their problem and try to work out what was upsetting them, and try to be very understanding with their anger” (Riddit 2015).

To mistake appropriate criticism for heckling would also be an error. What makes something “heckling” as opposed to meaningful criticism or engagement? The Mirriam-Webster dictionary defines “heckle” as “to interrupt (someone, such as a speaker or performer) by shouting annoying or rude comments or questions.” The term originated from the textile industry in the mid-nineteenth century - a group of radical textile workers in Scotland who “heckled” flax or hemp, meaning pulling apart the hemp or flax fibers (The Guardian 2006). The difference between heckling and meaningful engagement lies in the context and the manner in which it is delivered – heckling occurs in a public-speaking environment and implies intent to harass or embarrass the speaker.

Perhaps not in a picket line, but preparing and offering reasoned and rational responses to hecklers can only strengthen our rationale in the context of gray areas or areas of complexity in the field. A calm, well-reasoned response has the potential to increase our persuasiveness around issues of child advocacy – and enhance the role of child and adolescent psychiatrists as leaders for the well-being of children and families.

Hecklers, while rare, are important. Responding appropriately can 1) further enhance our role as child advocates, and 2) allow child and adolescent psychiatrists to better perceive, respond to, and reason through areas of complexity in the field. If child and adolescents psychiatrists are to be more publicly visible as child advocates, we may have to face hecklers again. According to one comedienne, “If you don’t deal with a heckler, you’re going to have a bad gig” (Comedy Courses 2011).

Ironically, I found out later that my heckler was herself a psychiatrist.

References


Dr. Larson is a consulting psychiatrist at an integrated behavioral health program in Maryland and assistant professor of psychiatry at Johns Hopkins Division of Child and Adolescent Psychiatry. Her areas of interest include systems of care, access to care for underserved populations, and service provision in integrated care settings. She may be reached at justinelarson72@gmail.com.
Honoring Our Mentors
Taking the time to say thank you to those who have made a significant difference in our professional and personal lives.

Tom Anders, MD
It may seem unnecessary to acknowledge a mentor who is one of the most celebrated child and adolescent psychiatrists of his generation. **Tom Anders, MD**, headed child psychiatry programs at SUNY Buffalo, Stanford University, and Brown; and trained many fellows who later became leaders in our field.

A few months into my own fellowship, I wrote a paper to submit for a meeting. I asked Tom to read it. The next day he handed it back to me, covered in red ink—edits, questions, suggestions. I thanked him and added, “But I guess it’s too late to submit to the meeting—it’s due tomorrow.” “Well, stay up tonight and get it done,” he said. I did, the paper was accepted, and I never forgot. The messages were clear—“If you want to get it right, you have to work hard...I believe you can do this...and that you should.” These were powerful messages at a critical time. I owe Tom a debt I can never repay.

~Charles H. Zeanah, Jr., MD

E. James Anthony, MD
It is truly my pleasure to honor **E. James Anthony, MD, FRCPsych**, who definitely was the most significant mentor and teacher in my professional life. During my two years of CAP training at Washington University he taught me so much about child and adolescent psychiatry, sharing generously his experiences working with Piaget and Anna Freud on a weekly basis, leaving us as trainees in such awe. But he taught me much more about being with patients, families, about listening, considering, always reevaluating. As I have aged I have thought more frequently about his description of himself as a “sessile” therapist with his child patients, staying in his chair instead of getting on the floor as he had at one time but still connecting totally with the child. His article “Communicating Therapeutically with the Child” (JAACP 31, January 1964, 108-125) is the first paper I share with new trainees every July, not having found anything since that comes close to capturing the essence of being with children with such empathy. And he is the only supervisor, who somehow could always make me, the unskilled trainee, feel like I was so intelligent, insightful, and competent when it was actually his unique sensitivities that facilitated my accomplishments; a skill I have so often tried to emulate in my supervision of trainees but have never come close to achieving. As the press release informing us of his death last December described him, Dr. Anthony was truly a “giant” in with accolades around the globe. But for me, and I am sure, for the many who were fortunate to work with him as patients and families, trainees, and colleagues, his influence in our professional and personal lives knows no bounds! Thank you, Dr. Anthony.

~Sandra Sexson, MD

Brian Barash, MD
Dr. Brian Barash was the first physician to support and nurture my dream of pursuing a career in psychiatry. He pushed me to become better throughout medical school and continues to support me during residency. He is one of the main reasons I am where I am today. Without his encouragement, I am not sure I would have had the confidence that led me to obtain not only my number one choice of residency, but also to continue to pursue my goal of obtaining a position as a child and adolescent fellow. Thank you Dr. B!

~Christine Duncan, MD
Sumru Bilge-Johnson, MD

My mentor is Dr. Sumru Bilge-Johnson. She has been there from the start when I had visions of starting my research in cyberbullying. She has been a great advocate and motivator when things got rough and motivations got lost. She was one of the driving forces that eventually led to the publication of our joint research in a journal. Seeing how she works with children and their family really helps me to understand how to handle very difficult situations, especially during the beginning of my career as a child and adolescent psychiatry fellow.

~Vishal Shah, MD

Maleta Boatman, MD

The senior child and adolescent psychiatrist that had the most lasting influence on my career in child and adolescent psychiatry was Maleta Boatman, MD, who for many years served as the chief of the in-patient Child and Adolescent Unit at Langley Porter Neuropsychiatric Institute at the University of California San Francisco. She took her work seriously and could at times be a difficult taskmaster. However, she proved willing to share all the clinical knowledge she had accumulated over her many years of practice, assuming her trainees, a term I abhorred, were willing to listen and learn. Although I was anything but one of her favorites, I came to admire and respect her commitment to insuring that excellent care was provided to those children hospitalized under her watchful eye. She was often late for appointments but wasted no time once settled in her office, which was always jam packed with journals, articles of interest, and charts under review, making whatever time remained count by providing excellent supervision. Although she often appeared slow to act in dealing with administrative matters her reasoning and decision making were invariably logical, clear, and to the point. One of her more interesting personal qualities was her ability to communicate nonverbally with her eyes, and she possessed a smile that when flashed could light up a room. Over the more than 30 years since concluding my fellowship, I have found myself, when faced with delicate and/or difficult clinical decisions, wondering aloud “What would Maleta do?”

~John Jones, MD

Walter Brown, MD
Sandra DeJong, MD
Zamir Nestelbaum, MD

In my journey through the world of medicine, I was fortunate to cross paths with Zamir Nestelbaum, MD, a psychiatrist remarkable for his clinical acumen, commitment to trainees and generosity of spirit. His support and faith in me helped me navigate critical crossroads. Paired with Walter Brown, MD, beloved teacher and gifted researcher, he encouraged me to pursue my passion for child and adolescent psychiatry, teaching, and research. Lastly, my thanks to Sandra DeJong, MD, whose warm and vibrant mind leads by example. She deftly juggles the roles of clinician, teacher, writer, researcher, leader, and mentor; constantly innovating, inspiring, and placing the impossible within the realm of possible.

~Deepika Shaligram, MD

Austin Butterfield, MD

Dr. Austin Butterfield is more than your average advisor. Over the five years we have known one another, he has taken the conscious initiative to foster a relationship of mutual growth and humility. He did this by intentionally creating a dialog about his own life, strengths, and weaknesses in ways far beyond a typical peer. When I was debating various specialties, he supported my decision without personal bias. When I struggled through an important rotation, he humbly shared his own experiences with adversity. And while I was creating my residency application, Dr. Butterfield was the one who met with me repeatedly to discuss the ideal strategy and programs that suited my best interests. He even showed me a copy of his own personal statement to demonstrate how difficult this task can be, which helped to normalize such a challenging process. Dr. Butterfield is an exemplary mentor who has empowered and guided me these past five years by sharing more of himself than a typical peer. His actions embody those of a true mentor.

~Charles Johnson, MD
Honoring Our Mentors  continued from page 87

Dennis Cantwell, MD

Dennis Cantwell was a Mentor to many UCLA Fellows prior to his untimely death. My child fellowship was 1977-79.

As all fellows from UCLA will remember, Dennis and Susan had a child each year, which was ideal for Child Development courses. He would simply bring in his son or daughter that exemplified the age we were studying. Those were remarkably exciting years.

One Journal club meeting on Autism in 1978 involved, in one room, the three leading investigator groups (of that time) of Autism in the world: Michael Rutter, Ed Ornitz, MD, and Barbara Fish, MD.

~Thomas K. Burchard, MD

Sucheta Connolly, MD

I have the honor and pleasure of knowing and working with Dr. Sucheta Connolly as a trainee. As an aspiring child and adolescent psychiatrist, she has been an amazing mentor over the past two years. Dr. Connolly has whole heartedly committed countless hours to offering invaluable advice and ongoing personal and professional guidance, for which I am grateful. She offers a listening ear, constant support, and has inspired me to similarly specialize in the treatment of anxiety disorders upon completion of my fellowship. Her willingness to share skills, knowledge, and expertise in addition to wisdom from her life’s experience is a selfless act that has transformed the way I view my life and child psychiatry. She has empowered me to confidently approach a myriad of personal and professional complications. She has the power to bring out the best in those who know her. Dr. Sucheta Connolly epitomizes the definition of a mentor.

~Toya Roberson, MD

Norbert B. Enzer, MD

Norbert Enzer, MD, was honored at the AACAP’s fiftieth anniversary for being one to the three leaders with the most lasting effect and making the most significant contributions to the Academy. Norb defines what a mentor should be. For me it was helping me choose the right paths and directions, remaining encouraging and supportive. Norb was an officer, identified the need for a code of ethics and then wrote it, was an outstanding program chair, constantly looking at opportunities. (For our 25th anniversary meeting in San Diego he invited the Director of the San Diego Zoo to present on parenting issues and problems in the zoo.) He chaired our committee to celebrate our history for the 50th meeting, resulting in amazing posters about our achievements. He tri-chaired Project Future and Co-Chaired Project Prevention. He co-chaired with Wun Jun Kim, MD, our Manpower Committee which defined manpower needs and strategies. Throughout all of the achievements he identified the potential for so many younger colleagues and encouraged them to get involved in the AACAP. These are a few of his leadership positions within the AACAP and he brought me along, educating me and so many others. Thank you Norb. – Ginger

P.S. And we had a lot of fun.

~Ginger Anthony

Norbert B. Enzer, MD

My First Mentor in Child Psychiatry

I entered LSU medical school determined to be a physician with broad interests and skills. And, while I had a vague interest in psychiatry and child psychiatry, at the time, it was not “physicianly-enough” for me. However, a chance, early encounter with Dr. Norbert Enzer, then Psychiatry Department chair, changed my life. His was a superb and highly respected physician (pediatrician as well as general and child psychiatrist) whose calm demeanor, warm smile, and respectful direction of my career interest became a magnet that inexorably drew back to child psychiatry as I tried hard to focus on other specialties, including pediatric neurology. With the well-known glint in his eye, he shared his fascination with children and how they functioned, as well as the
mysteries and power of human development as it played out in children, in health, and in disease. Norb left LSU as I graduated but he selflessly guided me to Duke instead of his own developing program. Throughout my career, he has encouraged my developing clinical skills, my research interests and, in 1978, dragged me into AACAP on the Program Committee that he was chairing. Through good times and bad, and even today, some 40 years later, Norb still offers clear, sage advice that helps me maintain my “physicianly role and identity” that makes me proud and satisfied in my career as a child and adolescent psychiatrist.

~Bennett L. Leventhal, MD

Ned Graffagnino, MD

Ned Graffagnino, MD, training director of the Hartford Child Psychiatry Training Consortium and director of the Child Psychiatry Clinic at The Institute of Living, was soft spoken, brilliant, kind, meticulous, and an unbelievably patient mentor with young trainees like me who thought they knew a lot without knowing what they didn’t know and needed to learn. His son, Chris, knew his football. We were lucky to be privy to meetings about the state of the art between Drs. Graffagnino and Al Solnit down in New Haven. Dr. Graffagnino’s equanimity and resolve in the face of emotional tyranny and tragedy in the lives of young people, continues to inspire. Thank you sir.

~Mitchell Alan Young, MD

Wun Jung Kim, MD, MPH
Garrett Sparks, MD

I would like to thank Dr. Wun Jung Kim, who I first met over two years ago as my APA Child Fellowship Mentor. Despite the conclusion of my APA Fellowship, he still continues to mentor me. His support, guidance, and encouragement meticulously tempered with brazen honesty are traits I highly value and appreciate. Even though we live in different states, he has and continues to be someone I know I can contact any time I have any career and/or life questions or concerns. I would also like to thank my AACAP News mentor, Dr. Garrett Sparks, who has been an invaluable source of knowledge and who has been very helpful in my first year as the AACAP News Resident Editor. Thank you to both of you!

~Harmony Raylen Abejuela, MD

From right to left: Harmony Abejuela, MD, Julie Zito, PhD, Wun Jung Kim, MD, Tim Dugan, MD, and Daniel Safer, MD taken at APA Annual Meeting after our workshop presentation on “Controversies Surrounding Pediatric Psychopharmacology: Learning to Integrate Psychopharmacology and Psychotherapy.”

Henrietta Leonard, MD

Dr. Henrietta Leonard became training director during my second year of residency at the Brown Triple Board Program. We were all awestruck by her energy, enthusiasm, and scientific approach to child and adolescent psychiatry. As a “mud phud” graduate, I was anxiously trying to figure out how to fit a research career with child and adolescent psychiatry. It was the mid-90s; I was still trying to make sense of the scientologists who protested at the American Academy of Pediatrics meetings against treating children for ADHD. As I grew into a physician, and Henrietta into her role as training director, I appreciated her candor and ethics as psychiatry grew more contentious about using medications to treat mental illness in children. When she was supervising me on a particularly difficult consultation, her most valuable advice was to do what I believed was right, just, and ethical when prescribing medications to children.

~Sufen Chiu, MD, PhD
Honoring Our Mentors continued from page 89

Bennett L. Leventhal, MD

When I became Program Committee chair a decade ago, I brought commitment and enthusiasm. And there was a lot to learn (i.e., I was pretty clueless).

Bennett Leventhal was my mentor for all of this. He coached me on how to do well the many required domain specific tasks: eliciting a full discussion of submissions on which reviewer opinions varied significantly, moving along graciously the occasionally lengthy discussions on which reviewers completely agreed, finding the right discussant to bring broader perspective to a symposium, encouraging submissions in areas critical to our field but at times underrepresented in our program, and mastering the surprising complexities of scheduling. All important and all fun to learn.

The most important thing he taught me was a skill I already thought I knew well: how to tell others disappointing news. I well understood how to be kind, discuss what was good, and to offer approaches to those areas that were problematic. He helped me learn to be more fully in the present and to slow down during this process. Sounds simple but it wasn’t for me. And it made a big difference.

Thanks Bennett.

~Neal Ryan, MD

Melvin Lewis, MD

I had joined the Yale Child Study Center for my child fellowship in the summer of 1999. A part of the faculty tradition was to welcome us fresh out of adult trainees and present the group with an autographed copy of Melvin Lewis’s textbook of Child and Adolescent Psychiatry. It was a cool and exciting ceremony but was equally overwhelming to receive such a big book with condensed information in tiny print. I remember meeting Melvin for the first time as he handed me my own, signed copy of the second edition. My first thought about him was that he must have been extremely dedicated and patient in order to edit such a voluminous book.

I first began to work with Melvin on a regular basis during the consultation liaison rotation in the first year of fellowship. I noted his warm, patient nature and the many gifted ways he interacted with children on the medical wards. Watching him do a developmentally appropriate mental status with a five-year-old with cancer was like watching a live version of his chapter in the book.

In the second year of my fellowship, I was assigned to work with Melvin more closely at the West Haven community clinic. It was during that time that I formed a very close relationship with him. I loved his supervision style and sense of humor. He was always soft-spoken and greatly supportive.

I remember at the time he was editing the third version of his famous book. He laid chapter copies all over the floor in his office and I would have to hop around piles of paper just to get to my chair for supervision. He once asked me if I had read the second edition that they had given us when we had joined. I jokingly told him I was waiting for the third edition before I started to read, hoping he would understand the overwhelming nature of our training and not having the time.

By the end of my training I had decided that if there was a mentor I would want to be like, it was Melvin. I was the last fellow that he would train, as after that year he went on a sabbatical. I was happy to buy the third edition of Melvin Lewis’s textbook of Child and Adolescent Psychiatry and actually read it. I was so excited about this achievement that I went back to Yale from New York just to have Melvin autograph it.

I was deeply saddened when I heard he passed away a few years ago. Now that I have taught over 12 batches of fellows myself, I fondly remember everything he taught me. I use techniques that he used and, if I find myself at crossroads, I ask myself “what would Mel do”? Sometimes I wonder if I will be half the mentor he was to me, but like he always told me, “there is always room for improvement.”

~Preetham Grandhi, MD
John F. McDermott, MD
Andrés Martin, MD, MPH

Writing about two unique individuals simultaneously is challenging, but Jack McDermott and Andrés Martin share several qualities, which makes it easier: a sharp intellectual rigor that goes hand in hand with a gentle, humorous touch; patience; an almost reactionary respect for the pun. They also share a genuine gratitude for the work of others.

Having mentors with the humility, wisdom, and integrity to respect other people’s work is truly powerful. They model respect in academic and editorial situations while providing substantive encouragement, which has helped us flourish as well as persevere through those discouraging moments that accompany any worthwhile project.

~Schuyler W. Henderson, MD, MPH
~Stacy Drury, MD, PhD
~Michelle S. Horner, DO

Octavio Pinell, MD

This one is a “no-brainer” for me and likely for anyone who was a psychiatry resident at the University of Texas - Houston. Dr. Octavio Pinell had, and still has, a huge influence on my own journey as a physician. He epitomized teaching and mentoring. He had an infectious personality that kept you coming back for more. You had to be prepared if you came face to face with him, you were about to be tested, and were about to learn something. Even saying hello to him may have elicited a response like, “Dr. Hess, what are four ways you can treat the sexual side effects of an antidepressant?” If you were lucky enough to know the answers, he would keep taking it one step further until he came across something you needed to look up. He was never condescending, and I was aware he was helping to build my knowledge base and force the really important things into long-term memory by relentless repetition. He always addressed all of us as doctors, even when we were still in medical school. Always respectful, but also reminding us of the awesome responsibility of being a physician. I loved getting paired up with him in clinic, because it was when you got to watch him with patients. He modeled such high standards and quality of patient care, and always had a checklist with him for each and every new patient he interviewed so that he would not miss anything. In my own practice, I keep a template much like his for all new patients and I use some of his interviewing techniques. As I am diagnosing and making treatment plans, all of those pearls of medicine he taught me still swim in my head and help me. I know I am a better doctor because of him and so are all of those who took the time to engage in the teacher/student process with him.

~Patricia Hess, MD

Ludwik Szymanski, MD

Dr. Ludwik Szymanski was my mentor during my fellowship at Children’s Hospital in Boston, 1990-1992. I spent a year doing subspecialty training in developmental disabilities through the Developmental Evaluation Center there. Dr. Szymanski’s enthusiasm for children and their families made the work joyful and intriguing! While it was a developmental center – he taught me so much about the typical and atypically developing children we met – he also planted the seeds for a profoundly integrated developmental understanding of and approach to all of child and adolescent psychiatry. His depth of knowledge and his gift for teaching, his warmth and compassion toward patients and me, and his support of my professional development are all foundations of my work and my identity as a physician and child and adolescent psychiatrist. Dr. Szymanski was a mentor, colleague, and friend. I would not be the doctor I am without him.

~Candida Fink, MD
Honoring Our Mentors continued from page 91

Lloyd Wells, MD, PhD

Dr. Lloyd Wells is not only an incredible clinician and a brilliant academician; beyond that he is an inspiring mentor who has supported and guided multiple generations of trainees on their paths into and through child psychiatry. I am fortunate and grateful to be one – among many – of his mentees!

~Brooke H. Rosen, MD

Laura B. Whiteley, MD

“We are all the same smart.”

Muscles relax, eyes that were glued downward lift to meet her gaze. She has managed the impossible—journal club is invigorating not dreadful. She has the precision of a surgeon in understanding how insecurity and shame creates barriers not only for her patients but also for students and staff, and finds the words and humor to alleviate these fears. This is why her patients return, why her Young Adult Clinic grows at an exponential rate, why colleagues request her when their children are struggling, and, finally, why I continue to grow as a clinician and friend under her mentorship.

~Marianna Kessimian, MD

Dr. Wells with the Mayo Medical School contingency at the Klingenstein Games in 2013.

THERE ARE GOOD REASONS
AMERICAN PROFESSIONAL AGENCY IS A LEADER IN PROVIDING MALPRACTICE INSURANCE FOR PSYCHIATRISTS
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Thank You to Bennett L. Leventhal, MD
Deputy Program Chair and Member Meeting Manager, 1980-2014

Thank you Bennett L. Leventhal, MD, leader extraordinaire, for 35 years of wisdom, innovation, and mentorship you used to advance science and research, to educate child and adolescent psychiatrists throughout the world.

For 35 years, Bennett has served as the onsite face of AACAP’s Annual Meeting. Skilled at seeing the possibilities and providing a vision, Bennett has the unique ability to anticipate challenges and map out solutions. Many members are familiar with Bennett’s onsite presence as the “fixer,” but few know the impact of his different roles within our meeting. Bennett has mentored hundreds, if not more, members, medical students, residents, monitors, first time presenters, program committee chairs, staff, and, particularly, international attendees. He has guided so many throughout the submission process, helping them understand the nuances of our meeting, always urging us forward in the field of science.

Bennett joined the Program Committee while in residency. He was a born conceptualizer of ideas, science, and space. AACAP’s 6 day meeting covers about 25 concurrent sessions three times a day. One of Bennett’s tasks was to break down our meeting, continually growing in size and attendance, into smaller groups that convey the message of camaraderie and relevance. The new research posters were born and offer opportunities for dialogue with our burgeoning number of scientists, to probe their findings and ask the questions relevant to advancing this specialty. Our membership has benefited at every level from how this part of the meeting has unfolded. Thank you, Bennett for using so many challenges to improve the AACAP experience.

Another emerging problem and solution that Bennett influenced was navigating AACAP’s relationship with the pharmaceutical industry. Early on, he recognized that if AACAP was to have a relationship with industry that it had to define the relationship in very specific terms. Following the 2002 Annual Meeting, Bennett worked with Larry Greenhill, MD, Program Committee chair, to draft the first version of AACAP’s Operating Principles for Extramural Support of AACAP Meetings and Related Activities. This began a successful dialogue that continues today.

Bennett has been integral to AACAP’s strong focus on conflict of interest and disclosure issues.

Each year the Annual Meeting goes through a rigorous evaluation process. For the past 9 years, participants have given the highest rating to “the AACAP meeting being free of commercial bias.” Bennett has also been instrumental in AACAP’s success with the Accreditation Council for Continuing Medical Education (ACCME). Bennett has worked collaboratively with staff to prepare our self-study report and has led AACAP’s televideo interview. Bennett was integral to AACAP receiving Accreditation with Commendation, the highest level possible, in 2006 and 2012. These initial efforts helped AACAP garner 4 six year grants for the NIDA K-12. This successful program has launched lasting careers in this area and our specialty.

As one of the first chairs of our Research Committee, Bennett was a singularly strong voice in urging the AACAP to establish an Office of Research. He made a cogent case and it was done. Later, while visiting the National Institute of Mental Health (NIMH), AACAP was encouraged to apply for a newly established program, the Early Investigator Award. AACAP was awarded the grant.

Bennett has been present in so many ways, extraordinarily available, to members and staff alike.

Virginia Q. Anthony and Bennett L. Leventhal, MD

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Thank You Bennett L. Leventhal, MD continued from page 93

which allowed us to wrap around the careers of and mentor young researchers. At the same time, Bennett began a dialogue with the National Institute of Drug Abuse (NIDA), which was well aware of the paucity of child and adolescent psychiatrists doing research in substance abuse. Bennett has been present in so many ways, extraordinarily available, to members and staff alike. So we use this opportunity to thank Bennett not only for his leadership at AACAP, but for the significant impact he has had on improving the science and growing the field of child and adolescent psychiatry.

Young-Shin Kim, MD, Bonnie Zima, MD, Bennett L. Leventhal, MD, Heidi Fordi, and Jill Brafford

E. James Anthony, MD, Virginia Q. Anthony, and Bennett L. Leventhal, MD

RUSH

MEDICAL DIRECTOR OF THE AUTISM RESEARCH AND TRAINING SERVICE CENTER (ARTS) – PSYCHIATRY

The Department of Psychiatry at Rush University Medical Center in Chicago is actively seeking a Medical Director for our Autism Research and Training Service Center (ARTS). We are seeking a Board Certified child and adolescent psychiatrist with a background and expertise in autism, both clinically and in research. The primary purpose for this position will be to develop appropriate clinical programming, advancing our autism treatment clinic. In addition to clinical work, this position will include public speaking, teaching and assisting in marketing the program. The candidate will support research projects, initiate the development of grants and IRB protocols, and work collaboratively within the institution as well as with other institutions throughout the city and country. Candidates should have a proven commitment to training residents and students and an established record of leadership. Qualified applicants will be eligible for faculty appointment at the Assistant Professor or above level.

Rush University Medical Center, located in downtown Chicago, is a national leader in academic medicine. Under the leadership of Mark Pollack, MD, The Grainger Professor and Chairman, the Department has been expanding its vibrant research, clinical and educational programs. It is recognized as the only Department of Psychiatry in Chicago ranked as a “high-performer” in US News and World Report. Our premiere academic medical center encompasses a 684-bed hospital serving adults and children. In January 2012, Rush opened a new 376-bed hospital building, known as the Tower, which is part of the Medical Center’s major renovation of its campus. Rush University is home to one of the first medical colleges in the Midwest and one of the nation’s top-ranked nursing colleges, as well as graduate programs in allied health, health systems management and biomedical research. The Medical Center also offers more than 70 highly selective residency and fellowship programs in medical and surgical specialties and subspecialties.

Interested applicants should forward their cover letter and CV via email to:

William J. Krech, III
Faculty Recruitment
William.Krech@rush.edu

Rush University Medical Center is an equal opportunity employer.
Cover Artist for the Journal

Schuyler W. Henderson, MD, MPH

At some point in the history of the Journal of the American Academy of Child and Adolescent Psychiatry, a formative decision was made: the journal will be orange. Why? Was it because a pumpkin-hued cover would remind readers of the most mischievous, wild, and externalizing of childhood holidays, Halloween? Were Dutch royalty on the editorial board? Or was it because, as the field was something of a latecomer, all the good colors were already picked?

For five decades, the monthly arrival of the Journal was heralded by that familiar flash of orange. And then, five years ago, a change: the pumpkin got a face, the cover got art. Where once there was the table of contents, now there were birds, bridges, brains, and pandas, and, twice yearly, recurrent images: an illustration of the location of the Annual Meeting for the October Journal. The Journal’s ampersand every January, signifying the many “ands” in our field: “child and adolescent,” “research and clinical practice,” “children and families.”

These cover illustrations have been created by Socorro Rivera.

Born in Mexico City, Ms. Rivera lived in the United States until she was nine, and then returned to Mexico City to study at the American School Foundation. She studied Graphic Design at the Universidad Anahuac in Mexico City and, after completing her degree, she chose to remain in what she called “this large and intense city,” where she works as a full time freelance designer.

Her journey into art began in childhood. “Ever since I was little,” she says, “I was interested in art. In my freshman year of high school, while taking an art class, I decided I wanted to do something creative for the rest of my life.” She attended a workshop with Lou Dorfsman, a leading graphic designer who oversaw Columbia Broadcasting System (CBS) logos and advertising. Her encounter with this productive graphic designer, she remembers, “was where I fell in love with this career.”

Socorro’s career took a turn for academia in 2008. Andrés Martin, MD, MPH, the new editor-in-chief of the Journal, was inspired by the covers of the American Journal of Psychiatry under Robert Freedman, MD, and Australasian Psychiatry under Garry Walter, MD, PhD, and invited Socorro to become the Journal’s cover artist.

How does she do it every month? The process begins with introspection and research. “Once I get the brief of what they’re looking for on the cover, I just start investigating what the topic is about, try and get a feeling of what the person may be going through, and start looking at everything around me, in the street, at other people,” she says. “This helps me to imagine what I want to project.”

Understanding the topic is one part of the creative process. Finding appropriate images is another. “I start thinking about the topic constantly. I can be walking in the street and maybe see a person, a situation, or an object that may relate to what I’m thinking about and I use it as inspiration. Sometimes I sketch it or take pictures, and other times I work on it directly on my computer using various design programs to achieve what I’m looking for.”

When asked about her inspiration, she doesn’t provide an eclectic list of famous and obscure influences; rather, she expresses a general admiration for the creativity she sees around her. “My major influences,” she says, “have been anyone who is creative, whether they are famous or not. Maybe a painter, a photographer, an architect, a dancer. Just any person who has the courage to create whatever s/he has in mind.” With admiration comes awe: “seeing things what others have imagined and then made come true [in art] just astounds me.”

When asked if there were any covers that she struggled with, she answers, “Yes, there have been several. I do so many rough drafts that I get a creative block. I have to stop to think about it for few a days and then go back and start over.” The work has its satisfaction and dissatisfaction. “There have been several covers where I’m not happy with the end product. There are also other covers that as soon as I know what it’s about, I can literally picture what it should look like. This is the process I love.”

Her favorite cover, she says, was the one “about children of illegal aliens and how they are separated from their families (when parents are deported). It continued on page 96
was one of the easiest covers. It really touched me since we constantly hear these stories in Mexico. I wanted it to be painful and aggressive so I didn’t hold back on the design.” And she didn’t. The cover is hatched with barbed wire and fencing, while a bound, grasping hand reaches towards a ghostly figure with a red heart lacerated by more wires. Blue figures float in the background. The vision is angry, it is plaintive, it evokes the heartbreak and scarring of enforced separation; it is an image that could come from so many episodes in history and makes a silent accusation: this is what people have done to families and children throughout history and this is what we continue to do.

The challenge of linking the art to the Journal’s content has been masterfully accepted by Mary Billingsley. In ‘Covered in this Issue’, Ms. Billingsley writes a blurb about the cover art where she says she gets to “explore the distinctly creative, expressive” side of the Journal, introducing “the intricacies and symbolism in the artwork” and tying “colors or images to details in the inspiration study.”

Ms. Billingsley says that the art has evolved over the years, as has the readership’s appreciation for the cover. She feels less need to explain it (which is a reminder of how radical it was for the Journal to put art on its cover, and for an academic journal to have a single, regular artist.)

For Socorro, her own interests continue to evolve. “I’d love to take some art classes, such as painting,” she says. “I painted in the past but would love to get into it again.”

Similarly, the Journal will evolve. As journals move online and the printed word becomes virtual, the role of cover art may change; Dr. Martin sees covers as “a dying art,” noting how “brilliant” covers by Jim Harris are now relegated to the inside pages of Archives of General Psychiatry. But a dying art is not dead yet. So while orange may not be the new black, the Journal continues to introduce itself with vivid art about the science and practice of child and adolescent psychiatry.

Note: the quotes come from email exchanges with Socorro Rivera, Mary Billingsley, and Andrés Martin. Although Socorro refused to be drawn into a discussion of the orange color of the Journal (“The orange doesn’t affect the design at all,” she said, politically and politely). Her answers to my questions were all in a Journal-orange font.

A gallery of covers is available at: www.jaacap.com/content/jaac-ImagesArchive.

Dr. Henderson is an assistant editor of the Journal of the American Academy of Child and Adolescent Psychiatry. He works at New York University and Bellevue Hospital.
What to Do When You Dread Your Bed: A Kid’s Guide to Overcoming Problems with Sleep

By Dawn Huebner, PhD, Illustrated by Bonnie Matthews

Magination Press, 2008
Paperback: 93 pages – $15.95

Practical and easy to read, this interactive book, one of many in the “What to do When” series, uses cognitive-behavioral techniques to address common problems children encounter in their attempts to fall asleep. The first section begins with an introduction that clinicians can use to help parents frame the importance of sleep and setting firm limits to help their children fall asleep. Each chapter contains enjoyable activities and games; it illustrates its main points by encouraging its readers to participate actively. Fun tips and suggestions to help with sleep are interspersed throughout the book, as are easily understood explanations for why these tips are recommended.

Normal Child and Adolescent Development: A Psychodynamic Primer

By Karen J. Gilmore, MD, and Pamela Meersand, PhD

American Psychiatric Publishing 2014
Paperback: 344 pages – $73.00

As senior consultant and medical director, respectively, of Columbia University’s Center for Psychoanalytic Training and Research, Drs. Gilmore and Meersand have written a comprehensive text for both budding and seasoned child and adolescent psychiatrists that will serve as a guide to various developmental phases of childhood and adolescence. Before delving into the early stages of development, the authors provide an introduction to the psychodynamics of developmental orientation. Each chapter discusses a different developmental stages starting from Infancy to Toddlerhood then going into the Oedipal Phase, Latency Phase, Preadolescence, Early and Mid-Adolescence, Late Adolescence, and Odyssey Years. It concludes by integrating the role developmental thinking plays in psychodynamic psychotherapy. Clinical vignettes designed to assist the reader in gaining a better understanding of the author’s central points are woven into each chapter. Companion videos that can be viewed online supplement the readings. The videos offer a visual dimension of learning that provides the scaffolding for major developmental transitions. All psychiatrists, including trainees, and other mental health workers, parents, and educators who work with children and adolescents could use this book to assist them in organizing their clinical thinking, deepening their appreciation for the patients’ minds and experiences, and providing guidance in how to best help them.
According to AACAP’s 61st Annual Meeting evaluations, the highest rated sessions in each presentation category were:

**Clinical Case Conference 12**: Addressing the Commercial Sexual Exploitation of Children  
Chair: **Yolanda Graham, MD**

**Clinical Consultation Breakfast 8**: Ethical Issues in Child and Adolescent Psychiatry  
Chair: **Adrian Sondheimer, MD**

**Clinical Perspectives 49**: Improving Student Mental Health and Decreasing Youth Suicide in South Korea: An International Collaboration  
Chair: **Un-Sun Chung, MD, PhD, PsyD**

**Honors Presentations 6**: Child and Adolescent Development: The Missing Foundation Piece in Education  
Chair: **James P. Comer, MD**

**Institute 9**: Fundamentals of Practical Pediatric Psychopharmacology for the Primary Care Clinician  
Chair: **Adelaide S. Robb, MD**

**Media Theatre 11**: *Ben X*: A Cinematic Presentation of Bullying and Autism  
Chair: **Jayapraba Vijaykumar, MD, MPH**

**Member Services Forum 6**: Beyond Advocacy Day: Bringing Advocacy Home  
Chair: **Sandra L. Fritsch, MD**

**Special Interest Study Group 6**: Family Interventions for Child and Adolescent Psychiatrists  
Chair: **John Sargent, MD**

**Symposium 29**: Health Promotion and Illness Prevention in Child Psychiatry  
Chair: **James J. Hudziak, MD**

**Workshop 19**: Parent Training for Child and Adolescent Psychiatrists  
Chair: **Amy Miranda, LCSW**

Please note that these rankings are determined by average overall ratings on session evaluations. Enrollment numbers did not influence ranking.

_Congratulations to all the presenters!_

We would like to acknowledge the first ten sessions to sell-out at AACAP’s 61st Annual Meeting. In chronological order based on sell-out date, they are:

**Clinical Consultation Breakfast 2**: Gender Nonconformity and Dysphoria Across Development: What the Child and Adolescent Psychiatrist Needs to Know  
Chair: **Scott F. Leibowitz, MD, and Cynthia Telingator, MD**

**Clinical Consultation Breakfast 3**: Master Clinician: Boris Birmaher, MD: Diagnosing and Treating Children With Severe Mood Problems  
Chair: **Boris Birmaher, MD**

**Clinical Consultation Breakfast 4**: Master Clinician: Harvey N. Kranzler, MD: The Psychotic Child and Adolescent: Difficulties in Assessment and Treatment  
Chair: **Harvey N. Kranzler, MD**

**Clinical Consultation Breakfast 7**: CPT 101: An Introduction to Coding and Reimbursement  
Chair: **Jason Chang, MD**

**Special Interest Study Group 9**: Pediatric Sleep Disorders  
Chair: **Jess P. Shatkin, MD, MPH, and Anna Ivanenko, MD, PhD**

**Workshop 19**: Parent Training for Child and Adolescent Psychiatrists  
Chair: **Amy Miranda, LCSW**

**Workshop 8**: Assessing and Treating Organizational Skills Deficits in ADHD: Guidance in Providing an Empirically Tested Method  
Chair: **Richard Gallagher, PhD**

**Workshop 23**: Learning Disabilities: Diagnostic Understanding and Implications for Psychiatric Treatment  
Chair: **Lee I. Ascherman, MD**

**Workshop 6**: Traumatic Brain Injury: Psychiatric and Educational Diagnosis and Management  
Chair: **Jeffrey E. Max, MD**

**Clinical Consultation Breakfast 13**: Anorexia Nervosa: What to Do When Treatment Fails for Kids and Teens  
Chair: **Victor Fornari, MD**

Thank you to all of the Annual Meeting speakers for your contributions to AACAP!
Did you miss this year’s Psychopharmacology Update Institute or Hansen Review Course?

Are you looking to learn something new?

AACAP has just what you need!

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

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

Be sure to also check out our two FREE sessions from the 61st Annual Meeting.

Visit AACAP’s Learning on Demand at aacap.sclivelearningcenter.com for more information.

Call for Exhibitors!

Don’t miss this opportunity to save money on your Annual Meeting registration!

AACAP members who refer a new Annual Meeting exhibitor can receive a $100 discount on their 62nd Annual Meeting registration.

All referrals must be first time AACAP exhibitors and must purchase a booth for AACAP’s 62nd Annual Meeting.

Exhibitors can connect with more than 4,000 child and adolescent psychiatrists and other medical professionals or advertise in several Annual Meeting publications. Typical AACAP exhibitors include recruiters, hospitals, residential treatment centers, medical publishers, and much more. An Invitation to Exhibit with more details on these opportunities as well as forms to sign up will be available starting in May at www.aacap.org/AnnualMeeting/2015.

Show your support for AACAP and save today!

Questions? Exhibits@aacap.org or 202.966.9518

No CME credit is available with session recordings. Session availability subject to speaker permission.
CALL FOR PAPERS

AACAP’s 62nd Annual Meeting takes place October 26-31, 2015, at the Henry B. Gonzalez Convention Center and Grand Hyatt San Antonio in San Antonio, Texas. 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, administration, etc. AACAP encourages submissions on neurodevelopmental interventions (helping children grow healthy brains), translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and violence prevention. Collaborative programs with colleagues in Mexico are also encouraged.

Verbal presentation submissions were due February 17, 2015 and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by Monday, June 15, 2015 and the online submission site will open in early April. All Call for Papers applications must be submitted online at www.aacap.org/AnnualMeeting/2015.

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

DONATE YOUR BIRTHDAY!

Make 2015 Special
Celebrate your birthday and AACAP at the same time!

Set up a personal fundraising page, and ask friends and family to make a donation to AACAP in lieu of presents.

To learn more, e-mail: Development@AACAP.org

The setup process is simple and easy.
Call Stephen at 202.966.7300 ext. 140. He will be happy to help you get started!
Psychiatry CME Retreat in Bali

“Master Training in the Psychiatric Treatment of Autism and Developmental Disabilities”

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Vital topics for your practice (22.5 CMEs):
- Autism & Devel. Disabilities Evidence-Based Practice
- Psychotherapeutic Interventions with Devel. Disabilities
- Psychological & Grief Responses to Cancer
- Cultural Diversity Exchange with Special Needs School
- Meditation Techniques
- Psychopharmacological Interventions

Retreat Education Facilitator:
Bob Kaehn, MD Child Psychiatrist
Medical Director, AZ Division of Dev.
Disabilities
Faculty, MIHS Child Psych Residency Program
This February, I am proud to celebrate my first anniversary with my AACAP family. Together we recruited more residents than ever before as part of the 100% Club, just in time for AACAP’s 61st Annual Meeting. We remained the nation’s leading organization of child and adolescent mental health experts, with AACAP members referenced in over 1,000 national and local news stories across the nation.

This year, we plan to do even better, and we want you to join us in reaching that goal together!

Here are three ways to get started:

1) 100% Club – Show Us YOUR AACAP Pride!
AACAP created the 100% Club to recognize programs that recruit all their residents. Last year, due to your collective efforts, we had 76 programs! This was no small feat. This year we’re aiming even higher. We’re counting on each and every one of you to help make our goal a reality. So, be sure to show us your AACAP pride and send us pictures of your team to help encourage others to join!

2) Sign up for AACAP News Clips and Stay in the Know!
Keep us in the loop about the great media work you are doing—it helps us not only promote your efforts but also to build on our media relationships. If you have not already done so, sign up for the News Clips by emailing Mona Noroozi at mnoroozi@aacap.org and be kept up to date on all relevant and current articles regarding our specialty.

The News Clips are sent every Monday, Wednesday, and Friday. They include brief AACAP updates as well as relevant and current articles regarding child and adolescent psychiatry—all in an informal, yet highly informative format.

3) AACAP’s Regional Media Network: Time to Put You to Work!
We are looking to grow our local or regional media point person list, and we need your help staying on top of media activity in your community.

Creating a Regional Media Network helps us increase our reach, recognition, and media responsiveness. If you want to reach a wider audience in your field of expertise, there is no better way than becoming a part of AACAP’s media team.

When breaking news hits and the media needs answers, we need you! For more information on the Regional Media Network, please contact Mona Noroozi at mnoroozi@aacap.org.

Get Connected and Stay Connected!

Mona Noroozi, Communications & Marketing Coordinator

Pay Your Dues Online

Follow these three easy steps!

2. Click on the Pay Dues Online at the bottom of the homepage.
3. Pay your dues!

It’s that easy!

Is Renewing Stressing You Out?

Relax! AACAP offers flexible payment solutions to meet your needs.

Make life easier. Take advantage of our monthly installment payment program. Contact Member Services at 202.966.7300 ext. 2004 to discuss your personalized payment plan options.

WE ARE GROWING!
apahoe/Douglas Mental Health Network is hiring both inpatient and outpatient psychiatrists in several locations within the metro area. Become a valued member of our provider team and practice community psychiatry at its best!

Arapahoe/Douglas Mental Health Network

• Sensible Work Schedule
• 42 Paid Days Off in the First Year
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Our Mission is to promote individual, family and community health by providing exceptional, compassionate, responsive, inclusive and integrated behavioral healthcare.

For immediate consideration, please contact Elisha Distin at 720-460-9358 or email at careers@ADMHN.org.
AACAP Policy Statement Requirements

Policies should:

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

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

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

Originated by Executive Committee, 222/93
Reviewed and Approved, 1/26/09

Policy Statement Procedures

- Once a final draft policy statement is submitted by an individual author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Group (PSAG) via the National Office,
- the Policy Statement Advisory Group Chair directs that:
  - the author(s) is told what major revisions or minor edits are necessary. After the author(s) has revised the statement, they may resubmit to the PSAC;
  - OR
  - the author(s) is informed that the statement does not meet the criteria for a policy statement.
- If the PSAG recommends it, the Executive Committee reviews the statement to decide whether it should be emailed to Council or placed on Council’s meeting agenda. If the Executive Committee decides not to advance the statement, the author(s) may be contacted to resolve the issue(s).
- If emailed, Council members have a two-week discussion period in which to convey concerns and ask questions. After this period, a one-week voting period begins.
- If Council approves the statement, the author(s) is notified. The statement is printed in AACAP News and distributed to the recommended sources then placed on the AACAP website.
- If Council does not approve the statement, the author(s) may be requested to rewrite and resubmit to the PSAG with an explanation of what changed.
- Every two years, the PSAG reviews all policy statements for necessary revisions or updates. Revisions are made by the original author(s), if available, or by known specialists in that area of expertise. The revising author(s) is given a 3-month period to make changes and resubmit to the PSAG for final approval.
- Annually, committee chairs are asked to review policy statements online and update if necessary.

*revised 06/2014
FOR YOUR INFORMATION

Thank You for Supporting AACAP!

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

Gifts Received January 1, 2015 – January 31, 2015

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Pilot Research Award
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Lois T. Flaherty, MD
in memory of David Ellis, MD

Where Most Needed
General Contribution
Carlos H. Salguero, MD, MPH

Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300 ext. 130.
**DID YOU KNOW**

**WHERE MOST NEEDED**
A donation “Where Most Needed” supports all of AACAP’s initiatives, and gives us the greatest flexibility to direct your contribution where it will have the biggest impact.

**E. JAMES ANTHONY FUND**
Created in memory of former AACAP President E. James Anthony, MD (1916-2014), the E. James Anthony IACAPAP Presidential Travel Award provides travel expenses for the sitting president of The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) to attend AACAP’s Annual Meeting, where his/her attendance will help foster greater international collaboration between child and adolescent psychiatrists.

*It costs $2,500 to award the E. James Anthony IACAPAP Presidential Travel Award each year.*

**RESEARCH**
It’s estimated that just 1% of child psychiatrists are researchers. We know that’s not nearly enough if we are going to accelerate innovation and best-practice gains. Without new researchers, we are facing the very real possibility of not reaching our potential for new medicines and treatments that will have lasting benefits to children with mental illness. Your donation will help us make more investments in promising new researchers.

*It costs $15,000 to launch one child psychiatry resident’s research career.*

**LIFE MEMBERS FUND**
The Life Members Fund supports medical students and residents interested in a career as child and adolescent psychiatrists with travel scholarships to AACAP’s Annual Meeting. At the meeting, they are mentored by Life Members, our most senior members. Since 2010, 100 medical students and residents have been supported by your donations.

*It costs $1,325 to sponsor a travel grant to the Annual Meeting for CAP Medical Students and Residents.*

**THE PARAMJIT T. JOSHI, MD INTERNATIONAL SCHOLARS AWARD**
This award, founded by AACAP President Paramjit T. Joshi, will recognize a member of the international medical community who has contributed significantly to best practices in effectively treating children with mental illnesses. The inaugural Paramjit T. Joshi, MD International Scholars Award will be given in 2016.

*It costs $2,500 to sponsor a travel scholarship for one international Child and Adolescent Psychiatrist or physician to attend the Annual Meeting.*

**THE ÜLKÜ ÜLGÜR, MD INTERNATIONAL SCHOLAR AWARD**
This award, founded by AACAP member Ülkü Ülgür, recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

*It costs $2,500 to sponsor a travel scholarship for one international Child and Adolescent Psychiatrist or physician to attend the Annual Meeting.*

**WORKFORCE DEVELOPMENT**
The average wait for a child to see a child and adolescent psychiatrist is seven and a half weeks; compared with two weeks for an adult to see a general psychiatrist. This deficit in our workforce has a devastating impact on children in need of treatment. The AACAP Medical Student Fellowship program helps eliminate the CAP deficit by encouraging the best and brightest young medical minds to pursue careers in child and adolescent psychiatry.

*It costs $3,500 to sponsor one medical student in a 12-week fellowship.*

**GENERAL INTERNATIONAL FUND**
The international medical community has contributed significantly to best practices in effectively treating children with mental illnesses. By recognizing and investing in the work of our international colleagues, your donation to the General International Fund will help us tackle the biggest barrier to access to services: a global shortage of child psychiatrists.

*It costs $2,500 to sponsor a travel scholarship for one international student or resident to attend the Annual Meeting and be mentored by an AACAP member.*

**ELAINE SCHLOSSER LEWIS FUND**
The Elaine Schlosser Lewis (ESL) Fund encourages innovative research in the areas of Attention Deficit Disorder/Attention Deficit Hyperactive Disorder and learning disabilities. It is through this research that physicians and mental health experts can improve the current diagnostic tools and treatment options for ADHD.

*It costs $15,000 to sponsor one ESL Pilot Research Award.*

**VIRGINIA Q. ANTHONY FUND**
Created to honor the service of AACAP’s retired Executive Director, the Virginia Q. Anthony Fund underwrites the annual Virginia Q. Anthony Outstanding Woman Leader Award, which celebrates the achievements of female CAPs who have had a profound impact on their field.

*It costs $2,000 to sponsor a Virginia Q. Anthony Outstanding Woman Leader Award.*

**CAMPAIGN FOR AMERICA’S KIDS (CFAK)**
CFAK funds projects that promote and support innovative initiatives in education and research that improve access to mental health treatments for all children.

**ENDOWMENT FUND**
A gift to the AACAP Endowment is a permanent financial investment in the future and stability of AACAP. The AACAP Endowment funds important programs that support AACAP’s mission for current and future generations.

Visit AACAP.org and direct your donation to any of the causes and funds listed above, and enjoy the freedom of targeting your gift exactly where you want it. To learn more about AACAP’s impact funds: Please contact the Office of Development at 202.966.7300 ext. 140 or development@aacap.org.
FOR YOUR INFORMATION

Child & Adolescent Psychiatrist

The Commonwealth Center for Children & Adolescents (CCCA) invites you to consider a Child and Adolescent Psychiatry position in the beautiful Shenandoah Valley. CCCA is Virginia’s only public acute psychiatric hospital for children and adolescents. CCCA serves youngsters with a variety of serious psychiatric and behavioral difficulties from across the Commonwealth. Treatment is provided in a relationship-based, collaborative, trauma-informed treatment model of care. The mission of CCCA is to provide high quality acute psychiatric evaluation, crisis stabilization, and intensive short-term treatment that empowers children and their families to make developmentally appropriate choices and that strengthens children’s hope, resilience and self esteem.

As Psychiatrist, you will be responsible for providing high quality psychiatric evaluations and treatment services to assigned child and adolescent clients and their families. You will function as a member of a collaborative, multidisciplinary team providing diagnostic evaluations, medication management and individual therapy for children and adolescents with significant psychiatric, emotional, behavioral, and environmental challenges.

For further requirements and to apply, please visit the Virginia Jobs at [http://jobs.virginia.gov/](http://jobs.virginia.gov/). Competitive salary with full state benefits including retirement plan, medical and dental insurance, disability plan, life insurance, etc. Deadline for receipt of applications is May 31, 2015; however, applications will be reviewed as they are received. Please contact our Human Resource office at (540) 332-2116 for further questions.

CCCA is an equal opportunity, affirmative action employer.

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ARS is currently looking for medical directors and Board Eligible/Board Certified Psychiatrists for our new state of the art facilities near Orlando and Sebring, Florida, and our state of the art facility near Colorado Springs, Colorado. Salary and benefits are nice and a relocation package is available.

If you are interested in joining our quality team, please contact or send CV to:
Sam Kelley, MD
Chief Medical Officer
skelley@advancedrecoverysystems.com

AACAP News

ADVERTISING RATES

Inside front, inside back or back cover $4,000
Full Page ........................ $2,000
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Third Page ........................ $1,100
Quarter Page ........................ $700

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November/December 2015 .......... September 27
January/February 2015 .............. November 27

DISCOUNTS

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- Advertisers who run ads three issues in a row receive a 5% discount.
- Advertisers who run ads six issues in a row receive a 10% discount.

For any/all questions regarding advertising in AACAP News contact communications@aacap.org.
LIFELONG LEARNING MODULES
Earn one year’s worth of both CME and self-assessment credit from one ABPN-approved source. Learn from approximately 30 journal articles, chosen by the Lifelong Learning Committee, on important topics and the latest research. Visit www.aacap.org/moc/modules to find out more about availability, credits, and pricing.

PERFORMANCE IN PRACTICE TOOLS
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AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved checklists and surveys to help fulfill the PIP component of your MOC requirements. Choose from over 14 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish.

AACAP: Your One Stop for MOC Resources
www.aacap.org/moc

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(www.aacap.org/cme)
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Annual Review Course — Up to 21 CME Credits
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One article per month is selected to offer 1 CME credit. Simply read the article, complete the short post-test and evaluation, and earn your CME credit. Up to 12 CME credits are available at any given time. Visit http://jaacap.org/cme/home for more information.

Questions? Contact Elizabeth Hughes, Assistant Director of Education and Recertification, at ehughes@aacap.org, or Quentin Bernhard III, CME Coordinator, at qbernhard@aacap.org.
AACAP Legislative Conference
April 23-24, 2015 ★ Washington, DC

Join us April 23-24, 2015, for AACAP’s Legislative Conference (formerly known as Advocacy Day) in Washington, DC!

During this two-day event, you’ll partner with fellow members, trainees, families, and youth to promote child and adolescent psychiatry on Capitol Hill.

Find out more information and register at www.aacap.org/legislativeconference.