Inside...

Thank You and See You in San Antonio • Paramjit T. Joshi, MD ....................................................... 205

Psychopharmacology Corner: Anxiety Disorder Treatment and Bipolar Disorder Treatment • Jeffrey R. Strawn, MD, John T. Walkup, MD, and Gabrielle A. Carlson, MD .............................................. 209

Women in Child and Adolescent Psychiatry Committee: Career Pathways as a Jungle Gym, Not a Ladder: Challenges and Opportunities • Karen Pierce, MD ................................................................. 214

Incoming AACAP President, Gregory K. Fritz (2015-2017): A Pioneer in Integrating Health and Mental Health Care • Diane K. Shrier, MD .................................................................................. 220

Annual Meeting Section ................................................................................................................ 225
SAVE THE DATES!

JANUARY 29-30, 2016

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Sheraton New York Times Square Hotel—New York, NY

Register by December 16 at www.aacap.org/psychopharm/2016.
Questions? E-mail meetings@aacap.org.
# TABLE of CONTENTS

## COLUMNS

**Jean Dunham, MD, Section Editor • jeandunham@gmail.com**

- Thank You and See You in San Antonio • Paramjit T. Joshi, MD ....................................................... 205
- Jerry M. Wiener Resident Member to Council: AACAP – My Beloved Adopted Family • Vandai Le, MD ....................................................... 206
- Systems of Care: New Systems of Care Columns to Be Coordinated by Mark Chenven, MD • Mark Chenven, MD ....................................................... 207
- Diversity and Culture: On Hiring an International Medical Graduate • Balkozar Adams, MD ....................................................... 208
- Psychopharmacology Corner: Anxiety Disorder Treatment and Bipolar Disorder Treatment • Jeffrey R. Strawn, MD, John T. Walkup, MD, and Gabrielle A. Carlson, MD ....................................................... 209
- Call for Nominations ............................................................................. 212

## COMMITTEES

**Ellen Heyneman, MD, Section Editor • eheyneman@uscd.edu**

- Women in Child and Adolescent Psychiatry Committee: Career Pathways as a Jungle Gym, Not a Ladder: Challenges and Opportunities • Karen Pierce, MD ....................................................... 214
- 2015 AACAP Election Results ............................................................................. 215
- CCAPS Spring Meeting Review • Daniel Savin, MD ....................................................... 216
- Ad Hoc Committee on Editorship and Publications ....................................................... 217

## NEWS

**Garrett M. Sparks, MD, Section Editor • sparksgm@upmc.edu**

- News Updates • Garrett Sparks, MD, MS ............................................................................. 218

## FEATURES

**Alvin Rosenfield, MD, Section Editor • arosen45@aol.com**

- Media Page: Harmony Raylen Abejuela, MD ............................................................................. 222

## 62ND ANNUAL MEETING

**Jon (Jack) McClellan, MD, Section Editor • drjack@u.washington.edu**

- Join Us at AACAP’s 62nd Annual Meeting! • Boris Birmaher, MD ....................................................... 225
- Back to Project Future: Opportunities for Members at AACAP’s 62nd Annual Meeting • Debra E. Koss, MD, Stephen J. Cozza, MD, and Neal D. Ryan, MD ....................................................... 226
- Focus On. . . • Gregory K. Fritz, MD ............................................................................. 227
- Annual Meeting Plenary Programs ............................................................................. 228
- Discover San Antonio ............................................................................. 231
- Guide to Exhibits ............................................................................. 233
- 2015 Annual Meeting Self-Assessment Exam ............................................................................. 233
- All About AACAP Pop-Up Events ............................................................................. 234

## FOR YOUR INFORMATION

- Membership Corner ............................................................................. 236
- The Childpsychopharm Listserv (CPLS) Consult With Colleagues in the Blink of an Eye ............................................................................. 236
- Welcome New Members ............................................................................. 237
- Thank You for Supporting AACAP! ............................................................................. 238
- AACAP Policy Statement Requirements and Policy Statement Procedures ............................................................................. 239
- Classifieds ............................................................................. 241

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**Cover:** Dedicated to Gregory K. Fritz, MD, president-elect, Christopher K. Varley, MD, who has served the News for so many years, and all the other AACAP members who love to fly fish.” – Alvin Rosenfield, MD
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

■ Establishes and supports the highest ethical and professional standards of clinical practice.
■ Advocates for the mental health and public health needs of children, adolescents, and families.
■ Promotes research, scholarship, training, and continued expansion of the scientific base of our profession.
■ Liases with other physicians and health care providers and collaborates with others who share common goals.

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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.

EDITOR................................................ Uma Rao, MD
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PRODUCTION EDITOR .................................Patricia J. Jutz, MA
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Andrés Martin, MD, MPH
Boris Birmaher, MD

COLUMN COORDINATORS
Ayesha Mian, MD, mian@bcm.tmc.edu
Timothy Dugan, MD, Timothy_Dugan@hms.harvard.edu
Sala S.N. Webb, MD, SWebb@mcvh-vcu.edu
Arden Dingle, MD, adingle@emory.edu
Rachel Ritvo, MD, rrrmd@comcast.net
Charles Joy, MD, crjoy1@gmail.com
Kim Masters, MD, kmater105@gmail.com
Mark Chenven, MD, mchenven@vistahill.org

American Academy of Child and Adolescent Psychiatry
WWW.AACAP.ORG
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016-3007
PHONE 202.966.7300 • FAX 202.966.2891
Thank You and See You in San Antonio

Dear Colleagues,

I want to thank all of you for the opportunity you gave me to serve as your president, and for the hard work and dedication of our volunteer leadership, membership, and staff. It has indeed been my honor and privilege to serve. I came to you with high expectations—and you delivered.

In my tenure as president, I have been delighted to both experience and witness renewed energy, enthusiasm, and optimism amongst our members and our beloved Academy. We have seen this in our positive sustained growth both in membership and member involvement in a number of different areas that are important to our field. Our community is made up of so many unique individuals, from different and varied backgrounds, all coming together to advance our mission. I am fortunate to have had the opportunity to work with all of you.

Our latest achievements on the international stage serve as a testament to not only AACAP’s global reach, but the importance and need for services and treatment for children all around the world—a topic close to my heart and the theme of my Presidential Initiative, Partnering for the World’s Children. We are moving in the right direction, building and strengthening our international collaborations and fostering these relationships while making sure we keep AACAP moving forward and on mission. It is my hope that the sharing of global ideas will serve AACAP and our field well as we work together to navigate our ever-changing specialty.

I am so looking forward to AACAP’s 62nd Annual Meeting, October 26-31, San Antonio, Texas, with special participation from the Asociacion Mexicana De Psiquiatria Infantil, A.C. (AMPI).

I am fortunate and pleased to be working with many colleagues from AMPI in making this year’s meeting truly a collaborative and global experience. With the added participation from our Mexican colleagues, you will notice a wide variety of programming with something for everyone.

Our Annual Meeting continues to attract increasing numbers of international attendees and we have seen substantial growth both in the number and quality of presentations that address global issues in children’s mental health. The depth, quality, and scope of presentations are unparalleled.

In particular, I encourage everyone to attend the Lawrence A. Stone, MD Plenary: An Invitation to Think Globally About Child Psychiatry, Saturday, October 31, 12:15-1:45 PM. This session features my dear friend and colleague, Joaquin Fuentes, MD, who will address initiatives that he has spearheaded on the international stage that are designed to foster collaboration, training, program-development, and policy issues that will renew our vision of ourselves and our field with an international perspective.

To learn more about international offerings, please visit the Annual Meeting section of the website.

As we continue to move forward, I want to thank you, our members, for your commitment, involvement, and passion. Without your support, we would not be the powerful professional medical organization we are today. Thank you for staying with us, for supporting our mission, and for your generous contributions of time and effort.

See you all in San Antonio!
entered medical school with the intention of becoming a neurosurgeon and, like most medical students, I changed my mind during my clinical rotations in the 3rd year. Do not be alarmed. This is not a story about how I fell in love with psychiatry. As I realized that my initial interest in neurosurgery and dissecting the human brain was merely a metaphor for my deep desire to delve into the human mind, I was quickly scooped up by a mentor, an adult psychiatrist at UCLA, who introduced me to his colleague, a child and adolescent psychiatrist. Before long, I attended my very first AACAP Annual Meeting, pursued my true profession, and never looked back.

I cannot recall which sessions I had attended during that very first Annual Meeting, but I remember very clearly the excitement and astonishment I felt throughout that amazing week in Chicago, Illinois, over Halloween week in 2008. I felt like an orphan meeting my amazing foster family for the very first time. I remember asking myself, “Who ARE these people? And why are they so nice?! Are they faking it? They must be! Real people, real doctors, aren’t this nice, are they? ” Although I questioned it, as I met more and more child and adolescent psychiatrists, I was reassured that it was all genuine kindness these child and adolescent psychiatrists were expressing to each other, and to me, the lowly medical student—the lowest on the totem pole that even hospital nurses do not always treat with respect.

Everyone smiled at me, looked me in the eye, took actual interest in getting to know who I was, where I was from, what led me to the meeting, what I wanted to do with my life, and what interests I had outside of medicine and medical school. They all treated me with respect. They were not afraid to act silly or be goofy. They even had a costume party for their Welcome Reception since it was Halloween (who does that at a professional meeting?), and they came all dressed up! There was a superman in his 70s, a cowgirl in pigtails, and lots of witches and fairies. And they even brought their kids to the party! They welcomed each other’s spouses and children like one welcomes long-lost relatives to a family reunion. It was the largest, silliest, and coolest party I had ever attended, and in Chicago to boot!

From child and adolescent psychiatry fellows who were several years ahead of me, to practicing child and adolescent psychiatrists who have been “grandfathered in” to the specialty, all of the physicians I met that week at the Annual Meeting were nice, funny, down-to-earth, REAL human beings who were not pretending to be high and mighty, nor exuding an arrogance that made you feel like you were worthless or did not belong. These “AACAP” people really seemed like a sincere, fun, and loving FAMILY! And I felt like I wanted that family to like me so badly! That way, maybe they would adopt me, because I really felt like I belonged there with them.

Unfortunately, I could not freeze time and remain at that Halloween party in Chicago forever. But fortunately, like you, I have come to adopt and be adopted by AACAP, the family that encompasses all those great physicians I met that fateful fall in Chicago, whom I respect and admire. To me, AACAP is truly a wonderful, loving, and supportive family; one that regularly feeds us with good, reliable knowledge to use and share with others. It teaches us with written and tangible materials, and in invisible ways that are only taught through caring interactions and long-term mentorship. It provides a safe environment where we are not afraid to ask questions or make mistakes. It gives us endless fond memories over which to laugh and reminisce with friends and colleagues. It offers a shoulder on which to cry when life does not go our way, or when sad things happen, such as our patients getting hurt. It helps us gather the strength and momentum to speak up for our patients and ourselves, and provides us with the strategies to succeed in our advocacy for change.

It supports us when we need help, but it does not harass or pressure us to act or practice our craft in one exact manner. It does not abuse or humiliate us when we make mistakes, but, instead, lays the proper foundation for moral judgment and ethical decisions in our clinical practice. When we need immediate guidance, it is always available to support us, night or day, rain or shine, 24/7 (just go on AACAP’s website at www.aacap.org and browse around for the extensive resources created for and available to us, e-mail the AACAP staff, or call a fellow AACAP member).

Every year, AACAP offers us the opportunity to establish new connections with colleagues who share the same passion of improving the mental health and well-being of children, adolescents, and their families, while simultaneously helping us reunite with old friends and mentors, near and far, whom we really care about and look up to but have not had dedicated time to see given the busyness of life.

In many ways, AACAP is like a large family that has so much love to give, it can and continues to adopt more and more trainees into its home, and each year it helps foster these “kids” to grow and blossom into competent, caring, and compassionate physicians who will, in turn, care for the many children and adolescents across the nation and around the world.

Through the years, AACAP has adopted me and loved me in all the ways described above, so much that, like

continued on page 207
New Systems of Care Column to Be Coordinated by Mark Chenven, MD

With the ever-expanding need to integrate and coordinate various community agencies and clinics, AACAP News has felt the increasing importance to shed light on this area. With deep gratitude, we are happy to announce that Mark Chenven, MD, has graciously agreed to take on the responsibility of coordinating a new column dedicated to various Systems of Care.

~Jean Dunham, MD, Columns Coordinator

“This is the first of a series of articles focusing on the issues of Systems of Care in child and adolescent psychiatry. I start the series with a reintroduction of the CASSP Principles from the 1984 National Institute of Mental Health sponsored Child and Adolescent Service Systems Program (CASSP). AACAP member, Ira Lourie, MD, participated in that effort to set a national standard for mental health care in community child and adolescent mental health programs.

“After 35 years, the world of behavioral health services has changed because of the efforts of CASSP, with core elements widely, but far from universally, incorporated into programming. Knowledge and skills in Systems of Care concerns is now a Core Competency in training and certification in child and adolescent psychiatry.

CASSP requires accessible, individualized, coordinated, self- and family-directed, interagency, trans-professional, collaborative care. Cultural competence, use of natural supports and wraparound services are intrinsic practices. Child psychiatry involvement and clinical leadership are needed at practice, advocacy, and policy levels.

“In less than 40 words, this expresses the ideal that quality care can be provided within a naturalistic, efficient community framework.

“All systems struggle with financial, administrative, technical, workforce, and other resource capacity issues in their own way: some do well; some do ‘well enough’; others struggle. Those that do best have two features:

1. They strive to operationalize CASSP Principles, and
2. They engage child and adolescent psychiatrists in leadership processes.

“CASSP Principles can guide reform in the healthcare environment by shaping practices of population management, integrated care (with routine screening, prevention, and referral), along with care coordination, and optimized use of community, agency, and school-based resources. Guiding principles include family engagement, cultural proficiency, clinical competence, team-based care, interagency collaboration, Quality Assurance/Quality Improvement (QA/QI), advocacy, and fiscal responsibility.

“Future articles will have contributions that expand on the Systems of Care perspective from Andres Pumariega, MD, Nancy Winters, MD, Kaye McGinty, MD, Justine Larson, MD, Gary Blau, PhD, and other leaders in the advancement of Systems of Care theory and practice.”

Dr. Chenven is former chair of the Committee on Systems of Care. He is Executive Medical Director at the Vista Hill Foundation and a Clinical Professor at University of California, San Diego. He may be reached at mcheven@vistahill.org.

AACAP – My Beloved Adopted Family continued from page 206

Dr. Le is the current Jerry M. Wiener Resident Member of Council. She recently completed her child and adolescent psychiatry fellowship at the UCLA Semel Institute and is working in Los Angeles and Orange County, California. She may be reached at vandaixie@yahoo.com.

some fortunate adopted children, I have almost forgotten that I was not born into this family but have only joined it less than a decade ago. That is what a loving, supportive, and nurturing family does for us; it makes us feel like we have always been there, from the very beginning. And now, we too, come to that annual reunion with open arms to foster and adopt new siblings into the “Family.” At least, this is how I feel towards AACAP and this year’s Annual Meeting.

DID YOU KNOW?

The original River Walk was built from 1938 to 1941 as a WPA (Work Project Act) at a cost of $430,000.
DIVERSITY AND CULTURE

On Hiring an International Medical Medical Graduate

When it comes to hiring a trainee or an attending psychiatrist, we all look for the same thing. We want a doctor who is knowledgeable, dependable, displays a strong work ethic, and is able to connect well with patients.

International Medical Graduates (IMGs) often fit the bill. Although they are sometimes overlooked, their life experience, determination to become psychiatrists, and ability to meet numerous challenges warrant a second look.

IMGs have immigrated to the United States from more than 140 countries and, recently, have filled one-third of residency positions (Gogineni et al. 2010). They have served as the backbone of child and adolescent psychiatry for many years but, as of late, they are being selected for fewer positions (Traverso et al. 2012).

Here’s why this is concerning: by the time IMGs sit down for their interviews, they have already made the decision to leave what is familiar to them, travel thousands of miles in hopes of a better life, and passed multiple exams. This is all in the pursuit of becoming the best psychiatrists they can be. In short, they have overcome adversity time and time again, making them not only stronger candidates but also reinforcing their resolve.

Their diversity— in terms of their cultural, linguistic, and religious backgrounds—is becoming more of a necessity and less of a luxury in our country’s ever-changing socio-cultural makeup (AACAP Pumariega, 2013). Having experienced life in at least two different countries, IMGs bring with them a cultural richness that they then share with others.

They are able to provide culturally sensitive care to their patients and families. In many cases, when patients speak of discrimination, IMGs know this difficulty firsthand. Often times, it can be comforting to have a psychiatrist with a similar cultural or ethnic background. And when traditional treatment is not working, IMGs can offer a unique viewpoint that may be able to improve the patient’s care. In addition, IMGs keep the lines of communication open with the rest of the world. IMGs are psychiatry’s unofficial ambassadors, sharing treatment approaches with psychiatrists across the seas and bringing home new ideas.

Taken together, these characteristics are invaluable. However, for IMGs to reach their full potential, employers must invest in them on the front end. It is an investment that can truly bear much fruit. Language barriers may at first seem like an obstacle, but with training, IMGs can quickly pick up American expressions. It may take greater understanding to help them appreciate all that comes with their patients born and raised in America, but as they have with so many challenges before, IMGs are often able and eager to overcome this.

Moreover, though visa issues may seem like a hindrance to hospitals and universities that should not be the case (Saeed et al 2011). Employers can ease that transition by working with the proper authorities, completing the necessary paperwork, and helping IMGs overcome the obstacles that face them. In turn, IMGs tend to be extremely grateful. This kind of support typically engenders loyalty toward their employer and prompts a desire to work even harder to meet the needs of their patients.

As we all know too well, psychiatry is a shortage specialty (Thomas and Holzer 2006). We need the best child and adolescent psychiatrists we can get to care for our patients and their families. Thankfully, we have found that in our American graduates. If we take a closer look, we will find that in our IMGs as well.

References


Traverso G, McMahon GT (2012). Residency training and international medical graduates: coming to America no more. JAMA 308(21):2193-2194

Dr. Adams is a child and adolescent psychiatrist and clinical associate professor of psychiatry at the University of Missouri-Columbia. She serves on the AACAP Diversity and Culture Committee. She may be reached at adamb@health.missouri.edu.
Anxiety Disorder Treatment and Bipolar Disorder Treatment

1. Julie has obsessive compulsive disorder (OCD) and social anxiety disorder. She suffered with those conditions for several years until age 14 when she developed a full-blown manic episode, which further intensified her anxiety. How would you treat Julie?

**Dr. Strawn**: First, with regard to her bipolar disorder, if there are no contraindications, I would begin quetiapine, based on positive randomized, controlled trials in adults with anxiety disorders and in adults with bipolar disorder and co-occurring anxiety. I would avoid second-generation antipsychotics with higher liability for akathisia.

Following initiation and titration of quetiapine, I would re-assess anxiety symptoms and would ensure that adequate psychotherapeutic interventions for her OCD/social anxiety had been attempted and optimized prior to any psychopharmacologic intervention for her OCD/social anxiety. In this regard, I would check the frequency, duration (ideally 8-12 weeks), and modality of the current psychotherapy, if applicable, as well as making note of factors such as compliance with psychotherapy and psychotherapist-patient alliance. Ultimately, from a psychopharmacologic standpoint, I would proceed with a very low-dose SSRI and would monitor any treatment-emergent manic or activation very closely. In this regard, I would make use of mood charting, both to increase her ability to attend to her affective and anxiety symptoms, and also to track mood and sleep. Finally, should Julie experience worsening manic symptoms following introduction of an antidepressant, I would consider—albeit in light of limited evidence (and no evidence for OCD)—a low-dose benzodiazepine or an alpha-2 agonist.

**Dr. Walkup**: Based on the case description we have to assume that the patient did indeed have a “full blown manic episode.” The only thing I might add to Dr. Strawn’s approach would be to make sure that the patient received a good lithium trial early in the treatment course. If really manic, I would definitely want to see what the patient looked like after acute stabilization with an antipsychotic and a lithium trial. The repetitive behaviors thought to be OCD might look different in that context.

But, I would take a step back and do a very careful history of this patient, first looking to make sure that the OCD diagnosis was correct and to confirm mania. I would see if a history of subsyndromal symptoms of mania might have been missed and make sure that the mania included Leibenluft et al. (2003) cardinal symptoms of mania – expansive, elevated mood (not just irritability), grandiosity, decreased need for sleep, and increased goal-directed activities.

There are a number of good reasons to doubt the diagnosis of mania at least for a while. 1) The prevalence of anxiety in this age group is upwards of 20 times more common than bipolar I—the horse and zebra problem of diagnosis. 2) As the anxiety disorders begin in childhood, young adolescents, like this patient, have often been symptomatic and untreated for a long while and accumulate a substantial amount of disability, due to poor coping and adaptation, accommodation by parents, and importantly catastrophic reactions to pressures and challenges. As a result, anxiety patients often get flooded and overwhelmed by routine experiences and demonstrate a loss of emotional control that could easily be considered mood lability or in the vernacular “mood swing.” 3) Perhaps most importantly, the diagnosis of mania moves one to pharmacological treatment quickly and includes, as Dr. Strawn suggests, antipsychotics and mood stabilizers, which do not do anything for the anxiety disorders. Also, too often clinicians have great hesitation to even consider antidepressants, which are the evidenced-based choice for the anxiety disorders, when there is minimal concern about bipolar. Lastly, the fear of missing bipolar disorder may result in it being over diagnosed and the under appreciation of the full range of

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*continued on page 209*
symptoms of untreated anxiety may lead to under treatment. In talking with our colleague Robert L. Findling, MD, MBA, he has joked that he sometimes refers to his Bipolar Disorder Clinic, as the Depolarizing Clinic (undoing false bipolar diagnoses). I think we do a fair bit of “depolarizing” in our Anxiety Disorders Clinic, too.

Dr. Carlson: I would add two things to the excellent points made. It is not just mania cardinal symptoms but how clear it is that something new and different has started. Like Dr. Walkup, I have seen more than one panic attack, with racing thoughts and agitation, be considered an episode of mania. On the other hand, I have seen a number of cases of people whose bearable symptoms of OCD have seen an onset whose bears most OCD symptoms very closely and would make getting worse with the onset of a manic episode.

2. Julie’s sister, Martha, also has severe anxiety disorder. How would you treat her?

Dr. Strawn: Certainly, Martha’s family history of bipolar disorder increases the likelihood that an antidepressant may be associated with tolerability concerns (Strawn et al. 2014); however, it does not preclude or contraindicate the use of an antidepressant. This being said, I would initiate an SSRI slowly and at a low dose. Moreover, I would carefully monitor any treatment-emergent manic or activation symptoms very closely and would make use of mood charting both to increase her ability to attend to her affective and anxiety symptoms, and also to track mood and sleep.

Dr. Walkup: Just another reason why the diagnosis is the most important part of the treatment process. If Julie is misdiagnosed with bipolar, it leads inexorably to treatment decisions in her first-degree relatives, like Martha. While we see this problem with siblings, the bigger issue is the diagnosis of bipolar disorder (1 or 2) in parents, which can tie the hands of a child prescriber who is considering strategies for treating the children with anxiety disorders. Otherwise, I like Dr. Strawn’s approach. Only thing I might differ on is that I do not consider activation, which is common (10-15%) as prognostic as a true manic switch, which is much more rare (<1%) in the large scale antidepressant trials.

Dr. Carlson: I have always made family members part of the decision-making process. I ask them which is preferable: putting your child on a drug s/he might not need (e.g., a “protective” mood stabilizer) or taking the risk of precipitating a manic episode. I agree that until I see data to the contrary, activation does not predict anything. It is the same issue we see in stimulants. Getting worse on a stimulant does not predict future mania (Carlson et al., 2000).

Dr. Strawn: Activation is commonly observed in the treatment of pediatric anxiety disorders and, in a recent meta-analysis of double-blind, placebo-controlled trials of youth with anxiety disorders, was associated with an odds ratio of 1.9 (Strawn et al. 2014). Regarding this transient increase in activity, restlessness and/or insomnia, 1) it is most commonly observed early in the course of treatment with antidepressants; 2) may follow a dose increase; and 3) is more common in younger patients (Labellarte et al. 2004; Reinblatt 2009; Walkup and Labellarte, 2001; Safer and Zito 2006). Generally, activation responds to a reduction in dose, in keeping with several studies, which have suggested that the risk of this adverse event is related to the pharmacokinetics of the medication in play (Reinblatt et al. 2009) and possibly to the serum drug concentration (Labellarte et al. 2004) or dose (Safer and Zito 2006). Thus, I would decrease the dose until activation has decreased and would reassure the patient and family that improvement is generally observed within several days, although this may be prolonged in the case of antidepressants with long half-lives (e.g., fluoxetine).

3. How would you treat a child with OCD who becomes activated on fluoxetine, if the activation occurs within the first few weeks of starting the medication?

Dr. Strawn: Activation generally occurs early in the course of treatment or after a dose increase. Thus, given that in this patient activation is occurring very late, I would be suspicious of secondary etiologies. In this regard, I would inquire as to whether there has been a recent increase in the antidepressant dose that precipitated this activation and would also explore the possibility that other medications had been introduced which could have precipitated the activation. For example, if the patient’s pediatrician had introduced a medication for anxiety-related gastrointestinal symptoms (e.g., a proton pump inhibitor or cimetidine, which both inhibit CYP2C19) or anxiety-related headaches (e.g., topiramate which inhibits CYP2C19), which are common in youth with anxiety disorders, it is possible that the serum
Dr. Walkup: We see late activation usually after a dose increase, but it is a much milder change than what is seen in the early low-dose activation. There is also a pattern of disinhibition and apathy associated with high dose SSRIs first reported by Hoehn-Saric and colleagues (1990, 1991) that we also see in kids, but it is usually not associated with activation symptoms but more typically, complex goal-directed behaviors that are uncharacteristic of the patient that present shortly after they got to the high dose SSRI. This symptom set is likely serotonin toxicity and requires a dose decrease (although some doctors misperceive the apathy as depression and raise the dose!). The problem with decreasing the dose is the risk of returning depression and, in some cases, suicidal behavior, so managing this set of symptoms is complex. Sometimes to maintain response in the context of reducing the dose of SSRI to decrease apathy or disinhibition, it may require an augmentation strategy like lithium, thyroid hormone, or antipsychotic to keep depression or anxious symptoms from returning. (N.B. Sometimes stimulants or dopaminergic agents like bupropion do a nice job of counteracting the apathy associated with high-dose SSRIs.)

Dr. Carlson: I would also not rule out the possibility that the patient actually had developed a manic episode—especially if there have been no dose adjustments or additions of other medications. In an adolescent with the onset of manic symptoms, mania must be considered. It may or may not have anything to do with medication treatment. In a longitudinal study of adults with well-diagnosed bipolar I disorder (Carlson et al., 2007), we found a complex relationship between antidepressants and mania induction. Some patients developed mania on one occasion when given an antidepressant, and not another occasion. So the vulnerability that causes someone to develop a bona fide manic episode on an antidepressant is not always present.

This information is intended to be educational in nature. It is not intended to constitute financial or legal advice. A financial advisor or attorney should be consulted if financial or legal advice is desired. All statements expressed in this column are those of the authors and do not reflect the opinions of the American Academy of Child and Adolescent Psychiatry.

References


CALL FOR NOMINATIONS

According to Article VI, Section 1 of the bylaws:

a) The Nominating Committee shall consist of the Immediate Past President and four General or Fellow members of AACAP who are neither officers nor members of Council. The Immediate Past President shall serve as chair of the committee. The other members of the Nominating Committee shall be elected. Each year Council shall propose a slate of four General or Fellow members of AACAP, of which two shall be elected by the general membership to serve a term of two years each.

The AACAP’s Nominating Committee is presently soliciting names for nominations for two Councilor-at-Large positions. The deadline for nominations is February 1, 2016. Nominations should be sent directly to any member of the Nominating Committee. Their contact information is as follows:

Paramjit T. Joshi, MD, Nominating Committee Chair
Children’s National Medical Center
111 Michigan Ave NW Fl 2.5 Rm 700
Washington, DC 20010
Phone: (202) 476-3922
pjoshi@cnmc.org

Kathleen Kelley, MD
University of Illinois-Chicago
1747 West Roosevelt Road (M/C 747)
Chicago, IL 60608
Phone: (312) 355-1402
kelley@psych.uic.edu

Rachel Ritvo, MD
4020 Everett Street
Kensington, MD 20895
Phone: (301) 946-9229
rziritvomd@gmail.com

Richard Martini, MD
100 N Mario Capecchi Dr
Salt Lake City, UT 84113
Phone: (801) 662-6755
richard.martini@hsc.utah.edu

Bonnie Zima, MD
10920 Wilshire Blvd Ste 300
Los Angeles, CA 90024
Phone: (310) 794-3714
bzima@mednet.ucla.edu

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Career Pathways as a Jungle Gym, Not a Ladder: Challenges and Opportunities

Karen Pierce, MD

This article is part of a series from the recently established Women in Child and Adolescent Psychiatry Committee providing information on career paths, negotiating job contracts, and integrating career and personal/family lives. A version of the material in this article was presented at the AACAP Annual Meeting in 2014. As many women child and adolescent psychiatrists have expressed interest in personal narratives, this article describes the author’s nonlinear pathway towards a rich and satisfying career and family life.

I did not start out to be a child and adolescent psychiatrist. Rather, I studied mathematics in college until my sister had an accident that left her on an orthopedic ward for 12 weeks. Spending every day at a hospital, where at the time broken bones were casted and splinted as inpatients, exposed me to the life of a chronic ward where young people’s lives were changed irrevocably by accidents ranging from motor cycles, cars, playgrounds, or youth sports. The ward was a sea of pain, both physically and emotionally. This secured my resolve to begin my path to become a physician who could help in a more comprehensive way to treat patients. Medical school could be difficult for a non-science major, but the exposure to human suffering with the hope of helping pulled me through. As a pediatric intern, I gathered a caseload of patients with psychological suffering so it was a natural to become a child and adolescent psychiatrist, as this was already my area of interest. The eclectic training at the University of Michigan exposed me to both the biological and psychological realms.

Initially, I was on a traditional linear path with an academic job when life showed up. My husband’s academic career shifted to another city, so I too chose to relocate. But, I was unable to find a job as a child and adolescent psychiatrist—there, I found that my biological psychiatry background was poorly understood by the heavily psychoanalytic community. Here is where my non-linear, “jungle gym” began. I scrambled to different paths and opportunities as they presented themselves. My linear course derailed, I discovered the fun of grabbing a wide variety of available handles and rungs. I worked in child guidance clinics in public health settings until I was offered the chance to start a child psychiatry program at an academic center. This was a golden time where I created a therapeutic school (that still is going strong) and later set up a child and adolescent psychiatry outpatient clinic. I had a wonderful chairman that understood my need for flexibility, as I had my two children during this time period.

I thought I had finally returned to that linear academic goal of writing, doing research, teaching, and clinical work— but wrong! Life intervened again. This time, my husband was diagnosed with cancer, which led to his decision to work part-time. All of a sudden, I became the primary bread winner; an awesome responsibility. I left full-time academia to establish a full-time private practice, but kept my involvement with several projects I had started at the University. I continued as a member of a weekly “think tank” consisting of a child neurologist, a special education psychological tester, a child neuropsychologist, and a child psychoanalyst. We met for many years, discussing how combinations of learning and psychological issues, and neuro-psychiatric factors, affect development. This group provided my academic sustenance as I worked too many hours in private practice to be the family’s provider. Fortunately, my husband recovered and resumed his full-time career. Simultaneously, another academic center offered me the opportunity to start a children’s partial hospitalization program on a part-time basis, while continuing my private practice on a part-time basis as well. I had the best of both worlds, seeing patients and families while teaching and providing care at an academic medical center.

Throughout my career, whenever I was offered the chance to do research, serve on a committee, educate public organizations, or consult to schools, I tried to say “yes” as often as possible, despite having little idea where each commitment would take me career-wise. I always checked in with my own wellbeing, my family’s needs, and my
current employment before jumping in totally. Starting a therapeutic school with certified learning disability teachers introduced me to professionals specializing in learning disabilities and working in schools. Interacting with school professionals allowed me to teach many of them in seminars about child and adolescent psychiatry and to serve as a consultant on their boards. In turn, I learned about classrooms and educational objectives by going to schools and talking to teachers and educational testers that further enhanced my ability to care for patients and their families.

Saying yes to being the child and adolescent psychiatry representative on the American Academy of Pediatrics Guideline Committee on ADHD in 1998 catapulted my interest in the pediatric world of ADHD. I returned to where I started my career: pediatrics. Part of the Pediatric ADHD guideline project included teaching learning modules to pediatricians on implementing these guidelines. Learning the theory and implementing behavior change in pediatric practice introduced me to the world of quality improvement. I continued to say “yes” when asked to do quality improvement for other groups on ADHD, childhood depression, and pediatric mental health practice. When the American Psychiatric Association (APA) began the committee on Quality, I was there to say yes and eventually become the chair of that committee. AMA and APA also asked me to consult to various projects on child mental health quality. I was rewarded with professional and personal growth, all because I said yes initially and took a chance. Now, I serve on committees in AACAP and the APA, both locally and nationally. My current interests are in the policy arena, working on legislation, advocating for youth in larger systems, consulting to schools, and spending time educating other clinicians about child psychiatry.

Lest I forget, none of this would be possible without the wonderful and loving support that I get from my family: husband, children, parents, friends, and colleagues. Life is a journey and as mindfulness practice reminds us: live each moment fully, without judgment, so as to be open to the opportunities that are out there. So, get on the playground, enjoy life, be flexible, and be open in order to find the path that works for you.

Dr. Pierce is in private practice and is associate clinical professor of Psychiatry, Feinberg School of Medicine; Distinguished Fellow of AACAP; and Distinguished Life Fellow of American Psychiatric Association. She may be reached at karenpierc@gmail.com.

More leaders will present their paths at AACAP 62nd Annual Meeting in San Antonio, Texas, October 26-31, 2015.
CCAPS Spring Meeting Review

Daniel Savin, MD
Associate Professor, Psychiatry
University of Colorado School of Medicine

The title for this year’s annual Colorado Child and Adolescent Psychiatry Society spring meeting was, “The Potential for Child Mental Health in the Coming Era of Integrated Care: Promises and Problems.” Our keynote speaker was Gregory K. Fritz, MD, professor and director, Division of Child and Adolescent Psychiatry at Brown University School of Medicine, and President-Elect of AACAP. With decades of experience as a consultation-liaison psychiatrist, teacher, researcher, and administrator working on the border of medicine and psychiatry, he was an ideal person to talk about this important topic. Other speakers included, Kyle Knierim, MD, Ayelet Talmi, PhD, Kim Kelsay, MD, Sonja O’Leary, MD, and Lauren Tolle, PhD, talked about prime examples in our own community where integrated care is taking place.

Dr. Fritz talked about the difficulties with access to care, the Affordable Care Act (ACA), and mental health parity—three major forces that push to integrate psychiatric care with medical care. Primary care is the most common location for children with mental/behavioral disorders to be seen: 50% of pediatric office visits involve behavioral, emotional, developmental, psychosocial, and/or educational concerns. While there are close to 300,000 pediatric primary care providers, there are, in the U.S., only 8,300 child and adolescents psychiatrists (CAPs), with shortages of pediatric psychologists and social workers as well. This shortage means that referral is often not possible, even if families could make the often-complex transition to a new provider’s office setting. In addition, the primary care setting offers the following advantages: familiarity with families, accessible location, less stigma, and a high level of trust. These advantages, together with the shortage of mental health providers, make enlisting primary care providers as front-line mental health resources of paramount importance.

The ACA, with its public health orientation, has already helped increase access to care. It also intends to increase quality of care and control costs, in part by having psychologists and psychiatrists to do more in consultation with primary care and do less direct patient care. He provided evidence from several studies that document the efficacy of collaborative care in pediatric settings, and cited the 2014 Millman Report, which estimates that collaboration of care, may save the health system up to $48 billion dollars per year.

Dr. Fritz hailed the 2008 Mental Health Parity Act as a big civil rights victory, ending government-sanctioned discrimination against a stigmatized group. This Act, not yet fully implemented, states among other things, that copays and annual or lifetime limits on care cannot differ between physical and mental conditions. Once parity is actually executed, there will be an increase in the number of patients seeking mental health services, augmenting access difficulties and highlighting the importance of the integrated care model.

Dr. Fritz reminded us that AACAP advocates for integrated care where child and adolescent psychiatrists collaborate closely with pediatricians and other primary care providers. AACAP has elaborated a set of principles for collaboration of care ranging all the way from primary prevention to specialty consultation and treatment, with increasing participation of the child and adolescent psychiatrist as problem severity increases.

Despite the promise of integrated care, Dr. Fritz stated that big solutions are needed for it to prosper: the fee for service system must end so that non face-to-face services can be reimbursed; mental health “carveouts” must end to ensure that the same provider groups can treat both physical and mental health conditions; mental health parity must be truly implemented; and, both primary health care providers and mental health specialists must be retrained in the collaborative care model.

Dr. Fritz hopes to advocate for these solutions during his tenure as president of AACAP.

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Ad Hoc Committee on Editorship and Publications


According to Article IX, Journal, Section 3 of the AACAP Bylaws, “An Ad Hoc Committee on the Editorship and Publications of the Academy of at least five Distinguished Fellow Members of the Academy shall be appointed by the President with the advice and consent of Council between the third and fifth year of the Editor’s term of office. The Ad Hoc Committee shall review the stewardship of the Editor in relation to the Editorial functions and publications. It shall discuss with the Editor any questions that have arisen during the current term of the Editor’s office. The Committee shall report in writing to Council. The Ad Hoc Committee shall provide a slate of nominees for the office of Editor to Council.” The Committee, as approved by AACAP Council, is as follows:

Matthew State, MD, Chair
University of California San Francisco
401 Parnassus Avenue
Suite 346
San Francisco, CA 94143
(415) 476-7730
matthew.state@ucsf.edu

Tami Benton, MD
The Children’s Hospital of Philadelphia
218 North Madison Ave.
Cherry Hill, NJ 08002-1068
(215) 590-1398
bentont@email.chop.edu

Regina Bussing, MD, MSHS
Univ. of Florida College of Medicine
PO Box 100234
Gainesville, FL 32610-0234
(352) 273-7550
rbussing@ufl.edu

Gabrielle A. Carlson, MD
SUNY Stony Brook
Stony Brook, NY 11794-0001
(631) 632-8840
gabrielle.carlson@StonyBrook.edu

Barbara Coffey, MD, MS
Icahn School of Medicine at Mount Sinai School
1240 Park Ave
New York, NY 10128-1753
(212) 659-1663
barbara.coffey@mssm.edu

Wun Jung Kim, MD, MPH
Rutgers/RWJ Medical School
671 Hoes Ln W Rm D453
Piscataway, NJ 08854-8021
(732) 235-2804
kimwj@upmc.edu

Bryan King, MD
Children's Hospital
P.O. Box 5371, Mailstop W3636
4800 Sandpoint Way NE
Seattle, WA 98105
(206) 987-1837
bhking@u.washington.edu

Daniel Pine, MD
NIMH
15K North Drive
MSC-2670, NIMH
Bethesda, MD 20892-2670
(301) 594-1318
daniel.pine@nih.gov

Neal D. Ryan, MD
University of Pittsburgh Medical Center
3945 Forbes Ave # 212
Pittsburgh, PA 15213-3507
(412) 383-5477
ryannd@upmc.edu

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Preschool Kids Treated for ADHD Likely to Stay on Medications Through Childhood

The Preschool ADHD Treatment Study (PATS) generated much of the data upon which most child and adolescent psychiatrists rely to prescribe medications to preschoolers with ADHD after they have failed psychosocial interventions. While PATS demonstrated that methylphenidate was both effective and safe for use in preschoolers with ADHD, these kids’ problems and disabilities do not magically end at the conclusion of a study. Fortunately, the PATS investigators were able to continue a naturalistic follow-up of about two-thirds of these preschoolers, re-assessing their use of medications at three years (mean age 7.4 years) and six years (mean age 10.4 years). Medication usage defined below means that the child has been taking the medication at least 50% of the time over the past six months.

Three years following the completion of the original PATS trial, about one-third of the subjects were on no pharmacotherapy at all. About 40% were on stimulant monotherapy, 9% on atomoxetine (alone or with a stimulant), 8% on an antipsychotic medication, and 7% on other pharmacotherapy. Overall, 65% were on an indicated ADHD medication.

At six-year follow-up, close to one-fourth of the subjects were on medications. Again, around 40% were on stimulant monotherapy, 4.5% were on atomoxetine (alone or with a stimulant), 13% were on an antipsychotic, and 15% were on other pharmacotherapy. Overall, 70.9% were on an indicated ADHD medication.

Subjects on antipsychotic medications tended to have other comorbid disorders, frequently a disruptive behavior (33-40% of the population) or autism spectrum disorder (about 6% of the population), as well as lower levels of psychosocial and academic functioning overall. Of note, autism spectrum disorder was an exclusion criterion on admission to PATS, so these were subjects who received the diagnosis later. Only one child each developed a comorbid psychotic or bipolar disorder. Eleven of the 24 children on an antipsychotic at Year 6 had been diagnosed with a tic disorder. The study was not able to assess co-occurring psychosocial interventions.

Preschoolers with ADHD severe enough to warrant stimulant medication continue to largely struggle with mental illness throughout childhood and have a heterogeneous treatment course ranging from being off of medications entirely to polypharmacy, though most remain on pharmacological treatment of some kind.


Kids With Psychiatric Illness Struggle More as Adults

Continuing the theme of longitudinally following children with psychiatric illnesses, another recent publication, this time a follow-up of the Great Smoky Mountain Study (a representative epidemiological study of 1,420 children from predominantly rural counties in North Carolina followed from 1993-2010), describes the persistent difficulties that youth with psychiatric illness, and even subthreshold symptoms, face as they transition into adulthood. Nearly 1,300 of these participants were assessed three times during young adulthood (at ages 19, 21, and around 25) for adverse outcomes related to health, the legal system, personal finances, and social functioning.

About 20% of those without childhood diagnoses or subthreshold symptoms reported adverse outcomes in these domains. However, about 40% of those with subthreshold symptoms and 60% of those with child psychiatric illness reported adverse outcomes.

Subjects with a childhood psychiatric disorder were six times more likely to have at least one adverse outcome in one of these domains, and nine times more likely to have more than one adverse outcome. Even subjects with subthreshold psychiatric problems were three times more likely to have at least one adverse outcome, and five times more likely to have more than one. These results persisted even when controlling for childhood psychosocial hardships and adult psychiatric diagnoses.

Among some of the worrying outcomes measured in the study, those with childhood psychiatric disorders were eight times more likely to have multiple addictions, 14 times more likely to be incarcerated, six times more likely to drop out of high school, and nine times more likely to be homeless.

In drawing attention to the public health burden of childhood psychopathology, such a study struggles to capture the effect that treatment may have in moderating the devastating impairment that can follow from childhood psychiatric illness or even significant subthreshold symptoms of psychiatric illness. As individual clinicians, we hope that we are able to help the children, who are able to get through our doors, beat these odds and live more fulfilling and functional adult lives. Unfortunately, studies like this point out just how much more work we have to do.

**Kids With Depressed Moms Have Accelerated Cellular Aging**

Telomeres are regions of repetitive nucleotides at the ends of chromosomes thought to protect the integrity of our DNA the same way that plastic tips at the end of shoelaces keep them from unravelling. The lengths of telomeres decrease as we age, ranging from around 8k base pairs in newborns compared to 1.5k base pairs in the elderly. Decrease in white blood cell telomere length may be a result of lifelong stressors leading to oxidative cellular damage. Telomeres in adults exposed to psychological stress and depression are shorter compared to controls.

Children with mothers with depression are at increased risk for depression and behavior problems. Researchers at the University of California at San Francisco followed about 200 children from a cohort of low-income Latino mothers and children from age 0-5 years, assessing exposure to maternal depression, childhood behaviors, and, eventually, telomere length. The study found that children with oppositional defiant disorder at ages 3, 4, or 5 years had telomeres that were about 450 base pairs shorter than those without. Independent predictors of oppositional defiant disorder and the shorter telomere lengths included exposure to maternal depression at age 3 years, shorter maternal telomere length (suggesting that the mother has been exposed to more stress herself), and younger paternal age at the birth of the child (perhaps a marker of socioeconomic stress).

These results suggest that exposure to maternal depression, long known to be associated with child behavior problems, has physiological correlates thought to be mediated by oxidative stress and perhaps with further longitudinal ramifications for both behavioral and physical health disorders.


**Anxious Parents Make Their Offspring Anxious Through the Environment, Not Through Genes**

Studies of monozygotic and dizygotic twins have done much to help researchers understand the relative contributions of genetics and environment across a multitude of medical conditions including psychiatric disorders. However, twin studies are in some ways limited. They can ascertain the proportion of the variance in children and adolescents due to their genetic and environmental influences, but they cannot specify the extent to which genes and the environment contribute to transmission from parents to their children. Some researchers now use an alternate twin model, the “children-of-twins” model that looks at adult twin pairs and their offspring.

This gets quite tricky, but this passage from the methods section of the paper clarifies.

By comparing correlations between children and their parent and contrasting this with correlations between children and their parent’s identical twin, we can learn about the influence of living with one’s parent over and above simply receiving 50% of their genes. Furthermore, by comparing the extent to which correlations between children and their twin uncle/aunt (avuncular correlations) differ for monozygotic and dizygotic twin families, we can infer the extent to which genetic and environmental factors influence transmission from one generation to another. Children from monozygotic families share a greater level of genetic influence with their uncle/aunt than dizygotic families. Thus, if children resemble their uncle/aunt to a greater extent in monozygotic families than in dizygotic families, this implies a genetic influence on transmission of the trait of interest. In contrast, if these two sets of correlations are similar, and are significantly lower than the parent-child correlations, this is indicative of an environmental mode of transmission.

Using data from the Twin and Offspring Study of Sweden, comprised of 385 monozygotic twin families and 486 dizygotic twin families, and assessing various anxiety measures in the twins and their offspring, then analyzing the data using structural equation models, the researchers were able to conclude that there really isn’t a lot of evidence for the genetic transmission of anxiety compared to environmental transmission. The authors also speculate about whether further studies could show whether this is limited to parental influences on offspring or whether the child anxiety also evokes parental anxiety.


**FDA Warns that the Methylphenidate Transdermal System Can Cause Permanent Skin Discoloration**

The FDA recently added a new warning to the methylphenidate transdermal system drug label to describe this discoloration, which is known as chemical leukoderma, or loss of skin color due to repeated exposure to specific chemical compounds. It is not harmful but is disfiguring, with areas of skin color loss ranging up to eight inches in diameter. The color change is not thought to be reversible.

There were 51 cases of chemical leukoderma reported to the FDA Adverse Event Reporting System database from April 2006 to December 2014, and at least one other published case, though there are likely others cases that have not been reported. Time of onset ranged from two months to four years of use. The discoloration was usually, but not always, at the site where the system was applied.

The methylphenidate transdermal system is an effective and novel delivery mechanism for a stimulant that can help solve some particular pharmacokinetic prescribing challenges, and it still has a small but important place in our pharmaceutical repertoire. However, in addition to our usual review of the risks and benefits of treatment choices, patients should be informed of the possibility of skin discoloration and educated to watch out for signs of skin discoloration when starting the methylphenidate transdermal system.


Gregory K. Fritz, MD, incoming president of AACAP, has had a long, innovative career in child and adolescent psychiatry. Although it was not linear or well-planned, it progressed in part because of his willingness to seize and embrace opportunities that were offered to him, and to work hard and do well at whatever he took on. He leads one of the largest child and adolescent psychiatry and triple board programs in the country and has major research funding. Nevertheless, he has managed to sustain numerous passionate interests outside of his work: hunting, fishing, dog training, and creative artistic projects.

Greg was born to religious parents who valued both education and careers that involved socially meaningful work to benefit others. His father, a metallurgical engineer who served in the U.S. Navy during World War II, worked for a series of large corporations and moved his wife and young family from Virginia to Nebraska, Wisconsin, Pennsylvania, and finally, when Greg was in the 6th grade, to Schenectady, New York. Greg graduated from Brown University with honors in American Literature. His mother, an excellent student and a feminist, had applied to medical school after college, but was rejected for being a woman and told she would just get married, have children, and drop out. Instead, she became a lab technician and, when Greg and his sister were in 6th and 4th grade respectively, went on to graduate school, earning a PhD in pathology and later becoming a research pathologist. Both parents thought that medicine would allow Greg to be independent rather than to work for a large corporation, and to do good, socially meaningful work.

Greg attended Tufts Medical School in Boston and found the first two years extremely boring. His interest in psychiatry began by chance during his first year of medical school. A psychiatrist at Tufts offered first-year students the opportunity to participate in psychiatric interviewing one hour a week and Greg jumped at the chance to do something clinical. However, his experience with psychiatry in Boston where Freud was held in awe and personality cults formed around Kohut, Melanie Klein, and others, was mixed. But he had been turned off by his pediatric rotation in medical school, by the focus on memorizing syndromes. He enjoyed doing surgical procedures, but not the other aspects of surgery, so psychiatry seemed the best fit.

After completing a rotating internship (surgery, pediatrics, medicine) in Boston, Greg and his wife, Nancy, relocated to San Mateo County, south of San Francisco, California, where he did his adult psychiatric training in community psychiatry, learning approaches that were quite different from the psychodynamic focus of Boston. During his PGY III year, he treated a couple of children under supervision. He performed well and with enthusiasm, so his child and adolescent psychiatry supervisor suggested he might want to go into the field. There was another turning point when this supervisor, on faculty at Stanford, promptly contacted the training director of the child psychiatry program. An interview was set up that day and next thing Greg knew he was in the child psychiatry training program. As always, he worked very hard and enjoyed it.

The child and adolescent psychiatrist who had the biggest influence on Greg’s career in child and adolescent psychiatry was and is Tom Anders, MD, who came to Stanford to serve as division director while Greg was in training. He invited Greg to do a chief residency and a research fellowship focusing on psychosomatic problems in children. However, the fellowship ended a couple of months early when a position in Consultation/Liaison opened up at Children’s Hospital at Stanford and Dr. Anders hired Greg. Consultation/Liaison was a perfect fit. Greg enjoyed both the medical and psychological aspects of the work, and developed what became his longstanding interest in how medical/biological, psychological and social factors influence physical diseases.

In the 11 years Greg was at Stanford, he and Nancy had three children and lived happily in the same house nearby in Half-Moon Bay, building an addition with the birth of each child. Nancy had been a paid staff of the McGovern Presidential campaign, but eventually became actively involved in a cooperative nursery school where she taught and held leadership positions.
But another, life-changing opportunity arose: Brown University recruited Dr. Anders to serve as director of the Child Psychiatry Division at both Bradley and Rhode Island Hospitals, and he recruited Greg in 1985 to establish a Child and Family Psychiatry service at Rhode Island Hospital, where pediatrics was based. Over the years, the program evolved: traditional child and adolescent psychiatry were at the Bradley Hospital and specialty services and medical/pyschiatric liaison services were at what became the Rhode Island Hospital/Hasbro Children’s Hospital.

Drawing on his Consultation/Liaison background, Greg established outpatient psychiatric services for children and adolescents with chronic medical illnesses. He also continued his strong clinical research emphasis. Greg came to Brown University with funding from National Institutes of Health (NIH) and from the W.T. Grant Foundation. Initially, he did research with survivors of childhood cancer, but at that time the oncology service in Rhode Island was too small to provide sufficient subjects. Soon, the AIDS epidemic led to another area of interest and research. Greg worked with Larry Brown, MD, on AIDS education and developed clinical services with Pediatrics, Behavioral Medicine, Child Psychiatry, and Child Psychology. Subsequently, Greg focused his research interests on asthma, which is the perfect psychosomatic illness to study because large numbers of children suffer from asthma and were available as potential research subjects. A wide range of psychological, social, cultural, and other factors contribute to different outcomes.

In 1992, Dr. Anders left Brown University for the University of California at Davis and Greg became division director at Brown University. He built one of the country’s largest programs in child and adolescent psychiatry with 90 full-time faculty in the Division, including 40 child and adolescent psychiatrists, 10 child psychiatry trainees, 15 Triple Board trainees (pediatrics, psychiatry, and child psychiatry), plus psychology postdoctoral fellows and a T-32 National Institute of Mental Health (NIMH) institutional research training grant.

Greg’s presidential initiative is focused on Collaborative Integrative Care involving pediatric and mental health care. Medicine is changing under the mandates of the Affordable Care Act. AACAP leadership and members have been collaborating with the American Academy of Pediatrics (AAP) and other organizations and have published a series of white papers in 2009, 2010, and 2012, all available on the AACAP website. In brief, Greg’s initiative involves five major overlapping areas: education (for both primary care and child mental health); establishing an AACAP resource center; liaison with AAP and a number of other relevant groups; advocacy; and evaluation involving outcomes data and cost/benefit analyses to change policy and secure funding. During Greg’s presidency, AACAP members will learn more about this initiative and its many aspects.

What are Greg’s future plans? During his two years as president of AACAP, he plans to go half-time at Brown University and give up most clinical work. At the end of his two-year presidency, he plans to step down as Division Director and retire. His hospital system has purchased its third and most complicated (though better) electronic medical record system, and Greg would prefer not to have to learn to use it. He and Nancy also have lots of other interests and ways they want to spend their time. He wants to learn to weld metal sculptures; to go hunting and fishing for extended periods of time; and to train bird dogs properly. He and his wife want to exchange their SUV for a pick-up truck and a 16-foot camping trailer, move away from their tightly packed schedule, and travel around the country visiting friends and relatives.

Of course, given his track record and the time and energy he has invested in his initiative, which builds on the sort of integrated physical and mental health programs he has worked on for his entire professional life, it is hard to imagine that Greg will be able to fully let go. He may find it hard to resist being drawn into some level of involvement in both clinical and policy research, as well as consultation to other programs and organizations on how to better integrate child and adolescent psychiatry/mental health into general medical/pediatric care. And, of course, he will still serve on AACAP’s Executive Committee as past-president for the two years after his presidency. Only time will tell. In the meantime, Gregory Fritz is clearly the right president with the right Presidential Initiative for AACAP at this time!

Dr. Shrier is clinical professor of Psychiatry and Pediatrics at George Washington University Medical Center in Washington, DC, and is contributing editor to AACAP News. She may be reached at dianeshrier@rcn.com.

DID YOU KNOW?
San Antonio is a bright and sunny city where the sun shines three hundred days a year and the average temperature is in the range of 70 degrees.
Helping Kids in Crisis: Managing Psychiatric Emergencies in Children and Adolescents

By Fadi Haddad, MD, and Ruth Gerson, MD
American Psychiatric Publishing 2015
Paper back: 213 pages – $55.00

Lead authors Dr. Haddad, director emeritus, and Dr. Gerson, current director, of Bellevue Hospital Children’s Comprehensive Psychiatric Emergency Program are both New York University professors. They offer a thorough instructive guide to managing patients in psychiatric crisis in the Emergency Room. The book addresses multiple topics pertinent to dealing with children and adolescents in crisis, such as “Aggression,” “Suicide and Self-injurious Behaviors,” “Tantrums and Behavioral Outbursts,” “Child Abuse and Trauma,” and “Risky Behaviors,” including “Substance Use.” They also include a section devoted to clinical and forensic psychological issues with at-risk youths and juvenile delinquents. Models of emergency psychiatric care are also covered. Children currently undergoing behavioral crises often present with escalating symptoms that overwhelm and scare their families. As trained clinical professionals, it is child psychiatrists’ job and duty to be able to quickly assess their safety and provide interventions that will de-escalate their behaviors in a limited amount of time and with limited resources. This book gives clinicians the knowledge and information to provide resources for families and in helping them find suitable treatment for their children. This book succeeds in guiding the management of unforeseen and unpredictable psychiatric emergencies commonly encountered when dealing with children and adolescents.

TREATING THE OTHER THIRD: Vicissitudes of Adolescent Development and Therapy

By H. Spencer Bloch
Karnac Books Ltd, 2015
286 pages – List Price: $42.95

Dr. H. Spencer Bloch is a certified adult and child and adolescent psychiatrist who also is a certified psychoanalyst, and has dedicated over 45 years to treating adults, adolescents and children psychoanalytically. His book’s title refers to the third of the child and adolescent patient population who are either treatment-refractory to medication or who refuse to take medications, and addresses what to do when faced with this arduous dilemma.

This book is divided into three main sections. The first discusses treating that other third, including the use of psychotherapy, to address severe psychopathology and bulimia in adolescents. The second deals with vicissitudes in development and understanding outliers. In that section, Dr. Bloch first discusses homosexuality and consequent dilemmas at the interface of psychiatry and politics, and then addresses the relationship between suicide and homicide, and dilemmas where psychiatry and the law interface. The third section delves into the interface of individual psychology and sociology, exploring the natural outcome of developmental needs by normalizing psychopathology and pathologizing normalcy in America.

The book uses clinical vignettes throughout, which highlight the main points of that particular section and help the reader understand the development of psychopathology and how to treat it when patients refuse medication or when psychopathology does not respond to medication. In addition, the author highlights the environmental influences on psychological development during this period in history when genetic and biochemical formulations are favored, and helps re-focus therapeutic efforts to treat psychopathology rather than solely dispensing medications. Throughout the book, adolescents’ developmental needs and vulnerabilities are explored and their therapeutic options are thoroughly discussed. This book helps equip child and adolescent psychiatrists with tools essential for managing psychotropic treatment-refractory child and adolescent patients. In the process, it assists in strengthening psychotherapeutic efforts and ensuing relationships with young patients.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Harmony Raylen Abejuela, MD, at Harmony.Abejuela@childrens.harvard.edu.
INDIVIDUALIZED CARE FOR YOUR MOST COMPLEX PATIENTS

Mayo Clinic utilizes pharmacogenomic evaluations and treatments for pediatric mood disorders so patients get exactly the care they need.

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PhRMA is a proud sponsor of the American Academy of Child & Adolescent Psychiatry

IT’S ALL OF US...

Against mental illness, heart disease, diabetes, Alzheimer’s, cancer, multiple sclerosis, HIV/AIDS, Parkinson’s, and more.

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And we’re working together.

PhRMA
RESEARCH — PROGRESS — HOPE
FromHopetoCures.org
On behalf of the entire Program Committee and AACAP Staff, we’re looking forward to seeing all of you at AACAP’s 62nd Annual Meeting, October 26-31, at the Grand Hyatt San Antonio and Henry B. Gonzalez Convention Center in sunny San Antonio!

We have a wide variety of submissions and some innovative topics, too. As always, the large majority of our sessions are accredited for continuing medical education (CME) credit; attendees can receive up to 50 CME credits by attending the entire meeting.

As you have come to expect, we will continue to offer:

✦ Complimentary wireless Internet throughout the meeting space at the Grand Hyatt and Convention Center!
✦ An improved AACAP App that not only allows you to fully navigate the meeting without paper (including the ability to complete all of your session evaluations electronically), but also gives you access to other AACAP information (like advocacy updates and a member directory)!
✦ Data Blitz and Poster Docent programs to help attendees get the most out of the new research poster sessions!
✦ PDFs of the Book of Scientific Proceedings, Program Book, and Honors Book to all attendees!

We are also pleased to welcome your families to San Antonio! Please see pages 231-233 for information on general guidelines for kids at the Annual Meeting and other San Antonio information for families. Do not miss out on some of my favorite activities including strolling along the beautiful San Antonio River Walk, riding around on San Antonio BCycles (a municipal bike sharing system), and learning about San Antonio’s unique history on the Mission Reach trail.

A special ¡gracias y bienvenido! to our colleagues from Asociación Mexicana de Psiquiatría Infantil, A.C. (AMPI) who are sharing the Annual Meeting with us this year. Make sure to see pages 228-230 for highlighted international sessions and events taking place at the Annual Meeting.

With important changes in the field, like the DSM-5, excessive use of electronics, new challenges with children of illegal immigrants, updated research in psychopharmacology, and international perspectives on child and adolescent psychiatry, mental health care professionals cannot afford to miss the Annual Meeting.

Visit www.aacap.org/AnnualMeeting/2015 for more information and to register! Online registration closes October 8.

See you in San Antonio,

Boris Birmaher, MD

Join Us at

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
ASOCIACIÓN MEXICANA DE PSIQUIATRÍA INFANTIL, A.C.

Join the conversation! Follow us on Twitter @AACAP and tweet about the Annual Meeting using #AACAPAM15
Back to Project Future: Opportunities for Members at AACAP’s 62nd Annual Meeting

Debra E. Koss, MD, Stephen J. Cozza, MD, and Neal D. Ryan, MD, BPF Implementation Task Force

Back to Project Future (BPF) was AACAP Past-president Martin J. Drell’s Presidential Initiative. It was designed to develop a consensus of future priorities and action steps for AACAP focusing on three key areas: Service/Clinical Practice, Training and Workforce, and Research. The report’s findings and recommendations were developed to be useful to child and adolescent psychiatrists in all academic, clinical, and administrative settings. The final 2013 BPF report defines a “shared vision” and “roadmap” of where the subspecialty of child and adolescent psychiatry is going and how AACAP can best prepare over the ensuing decade.

In 2013, the AACAP Executive Committee named the BPF Implementation Task Force to work with AACAP components, focusing on seven BPF recommendations identified as Council-approved priorities for 2013 to 2015. Multiple AACAP components, including the AACAP Assembly of Regional Organizations, Council, and committees have worked to incorporate these BPF recommendations into their ongoing activities.

AACAP members can learn more about priority BPF areas at the upcoming 2015 AACAP Annual Meeting in San Antonio, Texas. Many Annual Meeting presentations are relevant to BPF. The seven 2013-2015 BPF priorities and a sampling of corresponding Annual Meeting presentations are provided below. More program options are available on the AACAP website at www.aacap.org/AnnualMeeting/2015. Read the executive summary and full BPF report at www.aacap.org/aacap/Member_Resources/Back_to_Project_Future/Home.aspx.

Recommendation 1.1 (Integration of evidence-based treatments)
The vast majority of Annual Meeting programs present a variety of evidence-based treatments as they relate to clinical practice.

Recommendation 1.6 (Outcomes-based data)
- Workshop 2 – Expanding Clinician’s Toolbox: Using AACAP’s Quality of Evidence Tables to Make Treatment Recommendations

Recommendation 3.3 (Understanding and working with Accountable Care Organizations (ACOs) and the medical home model)
- Clinical Perspectives 21 – The Affordable Care Act and Pediatric Mental Health Care: Changes in the Practice of Child and Adolescent Psychiatry

Recommendation 4.5 (Collaboration with primary care providers)
See the Focus On article on page 227.

Recommendation 6.1 (Building a broad-based research agenda)
- Symposium 8 – Research Symposium
- Member Services Forum 5 – Building a National Institutes of Health Research Career and Understanding Grant Priorities

Recommendation 7.1 (Advocacy for child and adolescent psychiatrists)
- Member Services Forum 7 – Advocacy Update: Collaborative Innovation Strategies

Recommendation 8.5 (Addressing the needs of underserved areas using telepsychiatry, technologies, and other innovative methods)
- Clinical Perspectives 2 – How to Choose, Find or Build a Career Path: Unlimited Options Beyond Academia, Inpatient, or Outpatient
- Clinical Perspectives 37 – Implementation of Evidence-Based Practice in Child and Adolescent Psychiatry: Limitations and Ways to Make it Work
- Clinical Consultation Breakfast 12 – The Joys and Tribulations of Rural Child Psychiatry
- Clinical Perspectives 56 – Innovative Use of Technologies to Improve Quality of Child Mental Health Care
Focus On…

AACAP’s 62nd Annual Meeting takes place in San Antonio, Texas, October 26-31, 2015. This year’s programming encapsulates all the feedback from last year’s meeting and promises to offer even more engaging presentations, as well as robust discussions! Whether you are a medical student, resident, early career psychiatrist, or a seasoned professional, there is something for everyone. We have put a lot of effort into designing an Annual Meeting worthy of your very valuable time!

Included in the presentations and discussions are clinical issues, descriptions of new research, translational efforts, and updates on the latest in scientific research. As always, in addition to receiving a great education, you will have ample opportunity to socialize with your colleagues and meet new friends in a festive, southwestern setting.

My personal passion continues to be learning about and encouraging new approaches to integrated care; in fact, this is the focus of my presidential initiative. Integrated care is both challenging and exciting, and the Annual Meeting has a number of presentations dealing with this topic. The following are some I am particularly excited about.

I look forward to seeing you all in sunny San Antonio!

Institute 1: Advanced Child and Adolescent Psychopharmacology With Relevance to Primary Care Consultation (ticket)
Tuesday, October 27, 8:00 a.m.-5:00 p.m.

Clinical Perspectives 9: Integrated Emergency Mental Health Care: Canadian and American Perspectives (open)
Tuesday, October 27, 1:00 p.m.-4:00 p.m.

Clinical Perspectives 20: Integrating Behavioral Health Care Services in Pediatric Primary Care (open)
Wednesday, October 28, 8:00 a.m.-11:00 a.m.

Symposium 17: Simon Wile Symposium: Innovations and Directions in Behavioral Health Integration and Collaborative Care (open)
Wednesday, October 28, 1:00 p.m.-4:00 p.m.
Sponsored by AACAP’s Committee on Collaboration With Medical Professions

Clinical Perspectives 29: Collaborative Care Models: Experiences in Embedding Services Within Pediatrics (open)
Thursday, October 29, 8:30 a.m.-11:30 a.m.
Sponsored by AACAP’s Physically Ill Child Committee

Workshop 17: Preparing Child Psychiatry Fellows for Consultation and Collaboration With Primary Care (ticket)
Thursday, October 29, 8:30 a.m.-11:30 a.m.
Sponsored by AACAP’s Committee on Collaboration With Medical Professions and Training and Education Committee

Town Meeting: Integrated Care: Is It the Future for Child and Adolescent Psychiatry?
Thursday, October 29, 11:45 a.m.-1:45 p.m.

Workshop 33: Collaboration With Primary Care: Developing Clinical Skills, Overcoming System Challenges (ticket)
Friday, October 30, 1:30 p.m.-4:30 p.m.
Sponsored by AACAP’s Committee on Collaboration With Medical Professions

Workshop 35: Integrated Treatment of Adolescents With Self-Destructive Behavior (ticket)
Friday, October 30, 1:30 p.m.-4:30 p.m.

Symposium 37: Improving Identification and Treatment of Child Mental Health Conditions Through Pediatrician Education: Two Regional Responses (open)
Saturday, October 31: 9:00 a.m.-12:00 p.m.

Clinical Perspectives 62: Models of Collaborative Care and Intraprofessional Education Within Child Psychiatry Access Programs (open)
Saturday, October 31, 2:00 p.m.-5:00 p.m.
Sponsored by AACAP’s Committee on Collaboration With Medical Professions

Symposium 40: Collaborative Clinical Care for Youth in Child Welfare: A Comparison of Two Innovative Models (open)
Saturday, October 31, 2:00 p.m.-5:00 p.m.
Sponsored by AACAP’s Adoption and Foster Care Committee
Annual Meeting Plenary Programs

NOSHPITZ CLINE HISTORY LECTURE

Making Global Child Mental Health a Political Priority
Wednesday, October 28, 11:15 a.m.-12:45 p.m.

Mental disorders remain a major cause of suffering for children and adolescents worldwide, yet public health initiatives often fail to prioritize child and adolescent mental health. Why such a discrepancy? In the 2015 Noshpitz Cline History Lecture, Dr. Bruno Falissard will address the global burden of pediatric psychiatric disease, and review strategies to take to improve the lives of our children and families suffering with mental health issues throughout the world.

Bruno Falissard, MD, PhD, initially trained in mathematics and fundamental physics, earning his PhD in biostatistics and post doctorate in psychometrics and exploratory multidimensional methods, before pursuing medical and psychiatric training. Dr. Falissard is currently the head of the Master in Public Health of South-Paris University (600 students) and the head of the Center of Epidemiology and Population Health (500 members). He is co-author of approximately 400 papers and author of four books. His personal areas of research focus on the methodology and epistemology of mental health research. Since 2015, he has been the president of IACAPAP (International Association of Child and Adolescent Psychiatry and Allied Professions).

KARL MENNINGER, MD PLENARY

Child and Adolescent Psychiatry in the Era of Healthcare Reform
Wednesday, October 28, 4:15 p.m.-6:00 p.m.

In his inaugural address, “Child and Adolescent Psychiatry in the Era of Healthcare Reform,” Gregory K. Fritz, MD, AACAP President-Elect (2013-2015) will focus on the opportunities for improving the mental health care of children in this period of rapid change. Research is the key, lest anecdotes and individual preferences fill voids of empirical evidence. “Small r” research projects gain in importance as funding through the National Institutes of Health and industry becomes more restricted.

Dr. Fritz considers the reduction in the stigma of mental illness as an important factor behind much of the progress in child and adolescent psychiatry in the past decade. Yet, residual stigma remains a substantial obstacle. Dr. Fritz’s presidential initiative, the movement toward integrating mental health and primary medical care, is both a reflection of progress and a means to greatly expand children’s and adolescents’ access to mental health care.

In his presidential initiative, Dr. Fritz places a high priority on education – training primary care providers in basic psychiatric content as well as educating child and adolescent psychiatrists to be effective consultants and collaborators in the integrated care setting. He emphasizes the need for empirical evidence of improved outcomes and/or cost savings and for advocacy to remove the many administrative and financial barriers to integrated care that currently exist. He underlines the need for a new level of collaboration with pediatricians and other primary care providers, and with psychologists and other mental health care professionals.

Dr. Fritz is professor and director of Child and Adolescent Psychiatry and vice chair in the Department of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University. He is also the academic director at the E.P. Bradley Hospital and associate chief of Psychiatry at Rhode Island Hospital/Hasbro Children’s Hospital. Dr. Fritz chaired several committees in the AACAP and was elected councilor-at-large and secretary of the AACAP Council prior to becoming president-elect. He served as President of the Society of Professors of Child and Adolescent Psychiatry and of the International Society for the Advancement of Respiratory Psychophysiology. He has also been involved in the work of the Academy of Psychosomatic Medicine and the American Psychiatric Association, where he is a Distinguished Life Fellow. Dr. Fritz has published extensively on the psychophysiology of respiration, perception of physical symptoms, and minority disparities in pediatric asthma. He was the recipient of the AACAP Simon Wile Award for Leadership in Consultation Liaison Psychiatry and the AACAP Irving Phillips Award for Prevention.

The Karl Menninger, MD, Plenary is supported by Ronald K. Filippi, MD, in honor of his mentor, Karl Menninger, MD.
TOWN MEETING

Integrated Care: Is It the Future for Child and Adolescent Psychiatry?
Thursday, October 29, 11:45 a.m.-1:45 p.m.

Chair:
Gregory K. Fritz, MD

Co-presenters:
Robert J. Hilt, MD, Mary Margaret Gleason, MD, FAPP, and Randal M. Rockney, MD

In this program, participants learn the history of primary care physicians prescribing psychoactive medications and how they can enhance the process. Participants learn directly from a general pediatrician about the challenges, needs, and desires of primary care physicians caring for children with psychiatric disorders. Problems, barriers, and solutions to child psychiatrists’ involvement in integrated care are presented. In the ample discussion period, participants learn their own and their peers’ attitudes (pro and con) toward integrated care. Be sure to share your ideas about integrated care before the Annual Meeting by completing the brief survey from Dr. Fritz which has been emailed to all attendees.

PRESIDENTIAL INTERVIEW

Paramjit T. Joshi, MD, Interviews
Savita Malhotra, MD, PhD
Friday, October 30, 11:45 a.m.-1:15 p.m.

Dr. Savita Malhotra, an international leader in child mental health, is the head of Psychiatry and dean of the Postgraduate Institute of Medical Education and Research (PGIMER) in Chandigarh, India. Dr. Malhotra pioneered efforts to establish the discipline of child and adolescent psychiatry in India. Her main areas of research include epidemiology of childhood psychiatric disorders, neurobiology of childhood onset schizophrenia and pervasive developmental disorders, temperament, and psychopathology in children. Her most recent research involves development and implementation of a model telepsychiatry application to deliver mental health care to remote areas. The system has been extensively tested for its validity, reliability, and accuracy, and can be used as a model of service delivery in resource deficient countries. It is slated to be taken up at the national level in India. This project was awarded the highest order of merit and excellence as an e-governance project in India in a national level competition in 2014.

Will You Join?
Make a gift to AACAP in your will.
Ensure AACAP’s Future!
Visit www.aacap.org/1953_society to learn more!
LAWRENCE A. STONE, MD PLENARY

An Invitation to Think Globally About Child Psychiatry
Saturday, October 31, 12:15 p.m. – 1:45 p.m.

Plenary Speaker:
Joaquin Fuentes, MD

Joaquin Fuentes, MD, chief of Child and Adolescent Psychiatry at Policlínica Gipuzkoa, will discuss child psychiatry practice and research in the global community. Technological advances in social media and mobility now allow remarkable exchanges of ideas and cultures. Yet, in the global neighborhood, most children and adolescents do not have access to quality mental health care. In this plenary, Dr. Fuentes will review basic data and offer examples of international initiatives that foster collaboration, training, program development, and policy-making in order to improve child and adolescent mental health worldwide.

Joaquin Fuentes, a native of the Basque Country in Spain, completed his psychiatry residence at the Albany Medical Center Hospital, Albany, New York, and his child and adolescent psychiatry fellowship at the Western Psychiatric Institute and Clinic, University of Pittsburgh in Pennsylvania. He returned to his hometown in 1980 and has devoted his life to the interface of clinical practice, program development, education, research, and multi-departmental community actions in favor of children and adolescents. Dr. Fuentes’ main focus of interest has been autism spectrum disorder (ASD) and other developmental disorders. In 2014, as a key advisor for Autism Europe and a consultant to ASD national and European Union projects, he received the Child and Adolescent Psychiatry and Allied Professions (IACAPAP) Medal.

The Lawrence A. Stone, MD Plenary is named in honor of AACAP past-president and life fellow, Lawrence A. Stone, MD. It recognizes his leadership, vision, and passion to the mission of AACAP. Mrs. Marnette Stone endowed this plenary in loving tribute to her husband.
Here are a few highlights of what San Antonio has to offer. For more detailed descriptions, along with a longer list of activities, visit www.visitsanantonio.com/2015AACAP.

Explore the River Walk

The San Antonio River Walk is a verdant oasis of cypress-lined paved paths, arched stone bridges, and lush landscapes. It gently winds through the city center, providing millions of visitors each year with easy access to the city’s cultural hot spots, historic sites, and other attractions. The River Walk is the largest urban ecosystem in the nation. Tucked quietly below street level and only steps from the Alamo, it provides a serene and pleasant way to navigate the city. Ride a river cruiser, rent a bicycle, or take your time seeing the sights on foot. With 15 miles of sidewalks and paths, the River Walk provides access to museums, the King William Historic District, 300-year-old Spanish missions, hotels, shops, restaurants, and a new adventure around every turn.

History

San Antonio’s history is center stage with the Alamo and the likes of Davey Crockett and Jim Bowie, but it does not stop there. On the Mission Reach section of the expanded River Walk stand the Alamo’s four sister Spanish colonial missions, including Mission Concepción, the oldest un-restored stone church in the country.

Shop

Everything is extraordinary in San Antonio and the shopping scene is no exception. San Antonio’s got absolutely everything from high-end shopping to sprawling outlet malls. And if you are looking for something truly unique, try the many hand-crafted items on display in El Mercado, also known as Market Square, the largest Mexican market north of the Rio Grande.

Savor the Eats

San Antonio is home to one of the most exciting culinary scenes in the country. Featuring nationally recognized restaurants, the Culinary Institute of America, and chefs with so much flair there’s no telling what they will think of next. The Tex-Mex alone is worth the trip! Unless you have tried the local take on authentic dishes, you have never experienced enchiladas and fajitas quite like this.
**Nightlife**

Latin flair to smooth jazz to modern country to traditional mariachi, San Antonio’s live music scene is as unique and diverse as the city’s storied past. Enjoy everything from a little late night dancing to being serenaded at a River Walk restaurant.

**Family-Friendly Fun in San Antonio**

Are you looking for fun things to do with other families at AACAP’s 62nd Annual Meeting? The following activities have been organized by the Local Arrangements Committee for you to enjoy with fellow AACAP families. If you are interested, please meet at the Hospitality Desk located in the Registration area at the convention center at the designated time. You will be responsible for your own transportation and admission fees, however directions to each location will be provided on the day of the event.

**Wednesday, October 28**

**DoSeum**

The DoSeum (The-Doo-See-Um) is San Antonio’s only museum just for children where kids learn by doing, creating, and tinkering—instead of just looking and listening.

Meet at 9:00 a.m.

Admission is $11 for all ages.

**Thursday, October 29**

**Witte Museum**

Established in 1926 under the charter of the San Antonio Museum Association, The Witte Museum is located adjacent to Brackenridge Park in Midtown Brackenridge, San Antonio, on the banks of the San Antonio River. It is dedicated to natural history, science, and South Texas heritage. The permanent collection features historic artifacts and photographs, Texas art, textiles, the world-renowned Hertzberg Circus Collection, dinosaur bones, cave drawings, Texas wildlife dioramas, and the four-story H-E-B Science Treehouse; in addition to nationally acclaimed traveling exhibits.

Meet at 10:00 a.m.

Admission:

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<tr>
<th>Age Group</th>
<th>Price</th>
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<tr>
<td>Adults (ages 12-61)</td>
<td>$10.00</td>
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<td>Military (with ID)</td>
<td>$9.00</td>
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<tr>
<td>Seniors (ages 65 and up)</td>
<td>$9.00</td>
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<td>Children (ages 3-11)</td>
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<tr>
<td>Ages 2 and younger</td>
<td>FREE</td>
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**Friday, October 30**

**San Antonio Zoo**

The Zoo is home to over 9,000 animals representing 750 species of animals on 56 acres.

**Meet at 9:00 a.m.**

**Admission:**

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<td>Ages 2 and younger</td>
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Guide to Exhibits

Make plans to visit the Exhibit Hall where you can discover new products, network with colleagues, and access numerous resources. It is an excellent opportunity for attendees to access up-to-date information on products and services affiliated with child and adolescent psychiatry.

Plan your trip to the Exhibit Hall before the meeting by viewing an interactive exhibit hall floor plan on AACAP’s website at: https://aacap.confex.com/aacap/2015/exhibitorboothmap.cgi.

Download the Annual Meeting App (sponsored by American Professional Agency, Inc.) for your iPhone, iPad, and Android phone or tablet. Both the interactive floor plan and the App have exhibitor descriptions and contact information, so you can map out your route and make sure you do not miss any booths. Each attendee also receives a copy of the Exibits Guide on site with the floor plan and all of the exhibitor information.

The Exhibit Hall is located in Exhibit Hall A, on the Street Level of the Henry B. Gonzalez Convention Center.

Don’t miss this valuable part of the Annual Meeting!

And remember, 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. To review the Invitation to Exhibit with more details on these opportunities as well as forms to sign up, please visit: www.aacap.org/exhibits/2015.

Questions? exhibits@aacap.org or 202.966.9518.

2015 Annual Meeting Self-Assessment Exam

Registration for the Annual Meeting allows you to take advantage of this ABPN-approved self-assessment activity for FREE. Complete the 100-question exam and earn 8 AMA PRA Category 1 Credits that count toward the CME and self-assessment requirements of MOC. Do it early! And then, use feedback from the exam to guide your selection of programs at this year’s Annual Meeting. (This exam will be available until November 7, 2015.)

Not Attending the Annual Meeting?

You can purchase access to the 2015 AACAP Annual Meeting Self-Assessment Exam online at www.aacap.org/annualmeeting/2015.
All About AACAP Pop-Up Events

**JAACAP Connect**

Interested in learning more about JAACAP and JAACAP Connect?

Thinking about getting involved, but not sure where to start? Then stop by the JAACAP Connect pop-up event!

_**JAACAP Connect Editor-in-Chief and John F. McDermott, Assistant Editor-in-Residence Michelle S. Horner, DO, and incoming John F. McDermott Assistant Editor-in-Residence Oliver M. Stroeh, MD, will be available to answer your questions.**_

**Consumer Issues**

*Get the FACTS!*

Make sure to stop by the registration area and learn all about AACAP’s consumer-friendly products including Facts for Families, Resource Centers, and so much more!

**Development**

You’re invited to join the 1953 Society

Come speak with AACAP Deputy Director of Development Alan Ezagui about the importance of planning ahead and the value of creating a permanent legacy to support new research, mentor young child and adolescent psychiatrists, and help children with mental illness.

AACAP’s Newest Lifelong Learning Module Now Available

AACAP is proud to announce the upcoming release of Lifelong Learning Module 12: Relevant Clinical Updates for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 38 AMA PRA Category 1 Credits™ (8 of which will count towards the ABPN’s self-assessment requirement).

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For questions about Module 12 or maintenance of certification, please contact Quentin Bernhard III, CME Manager, at 202.587.9675 or at qbernhard@aacap.org.

**SPECIAL PROMOTION**

Order Module 12 when you pay your 2016 membership dues by January 31, 2016 and SAVE $60!

Look on your dues renewal form for more information.
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.

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.

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

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.

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.

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.

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.

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.

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.

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 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.

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.
Don’t make another New Year’s resolution to stop procrastinating. Jump start 2016 by renewing your AACAP membership between October and December of this year. Members are mailed invoice the first week of October to encourage early renewal.

Kudos to Geraldine S. Fox, MD, Recipient of the 2015 APA Vestermark Psychiatry Educator Award!

Geraldine S. Fox, MD, received the 2015 APA Vestermark Psychiatry Educator Award for her excellence, leadership and creativity in the field of psychiatric education. This APA annual award was established in 1969 in memory of Seymour Vestermark, M.D., who was chief of the National Institute of Mental Health Training Branch from 1948 to 1959 and an authority in the field of professional mental health education.

The Childpsychopharm Listserv (CPLS)* Consult With Colleagues in the Blink of an Eye

The ChildPsychopharm Listserv (CPLS) is an email discussion list created for child and adolescent psychiatrists and other mental health professionals. The CPLS is managed and moderated by Howard Rudominer, MD, an AACAP Life Member.

The CPLS is a FREE, active, and lively online discussion group comprised of multidisciplinary professionals who share experiences, ask, answer, and cover the myriad of issues facing our specialty.

On the CPLS, a subscriber uses the mailing list to send messages to one, or all, other subscribers. Based on the topic and interests, subscribers can respond to an individual or the whole group. From there, discussion and information exchanges can – and definitely do – occur. All subscribers to the CPLS have access to the listserv archive. A valuable source of information, the archive contains a robust collection of content and messages dating back years.

The CPLS is particularly helpful for residents, early career psychiatrists, rural psychiatrists, and those in private practice. The CPLS is not limited to only psychopharmacological issues. It provides an arena to discuss matters of clinical practice including diagnoses, medication, research, referrals, and types and techniques of various psychotherapeutic modalities.

As a member of the CPLS, one can even learn about new research before it is published!

Joining is easy and free! For more information contact Dr. Howard Rudominer directly at hrudmd@gmail.com.

* The CPLS is not an official AACAP program or product. Any/all appearance of content or external hyperlinks does not constitute endorsement by AACAP of the content, websites, or the information, products, or services contained therein. AACAP is not responsible for the content or of any web pages referenced from the CPLS. For all questions, please contact communications@aacap.org.
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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.

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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.
**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.

*revised 06/2014

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**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.

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

*revised 06/2014*
MAKE A DONATION.
MAKE HOPE.
MAKE AN IMPACT.

Classifieds

FLORIDA
Jacksonville, FL
The University of Florida Department of Psychiatry Jacksonville has the following position openings:

CHILD PSYCHIATRIST
Requisition #0906335; position #001302
Provide clinical services for children and adolescents in the outpatient clinic. Specialty training and/or board certification in child and adolescent psychiatry is required.

PSYCHIATRIST–EMERGENCY DEPARTMENT
Requisition #0904917; position #00028647
Provide consultation and resident supervision in the Emergency Department, provide services in the outpatient clinic and board eligible/board certified in adult psychiatry.

FORENSIC PSYCHIATRIST
Requisition #0904244; position #00028387
Successful candidates must be board eligible/board certified in forensic psychiatry. Must have completed a subspecialty fellowship in forensic psychiatry and possess excellent diagnostic skills.

The above positions are for a full time faculty member at the tenure/ non-tenure accruing level of Assistant/Associate Professor. Candidates must possess a MD degree or equivalent and be qualified for an unrestricted physician license in Florida. Salary is negotiable; benefits are excellent. The University of Florida is an equal opportunity institution dedicated to building a broadly diverse and inclusive faculty and staff. Qualified applicants should submit a letter of interest which includes a curriculum vitae and three letters of recommendation to: www.jobs.ufl.edu by referencing the requisition and position number above.

Internal Number: 0906335; 0904917; 0904244

ILLINOIS
MEDICAL DIRECTOR
ADOLESCENT IOP AND PHP
Chicago’s Northern Suburbs
Deerfield, IL
NorthShore University HealthSystem (NorthShore), the principal academic affiliate of the University of Chicago Pritzker School of Medicine, seeks an exceptional and energetic Child & Adolescent Psychiatrist to serve as Medical Director of the Adolescent Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP). The successful candidate for this position will be BC/BE by the ABPN and have completed a Child & Adolescent Psychiatry Fellowship.

The position involves leadership of an innovative team, clinical work (patients in the programs as well as office patients), and teaching. The IOP and PHP employ evidence-based treatments, including cognitive behavioral therapy, mindfulness, pet therapy, art therapy, yoga, meditation, and the projected addition soon of auricular acupuncture and qigong, to assist adolescents with a range of diagnoses, such as mood disorders, anxiety, self harm, and school avoidance.

Take advantage of this unique opportunity to:

• Enjoy the collegiality and intellectual stimulation of an academic center with a compensation and benefits package competitive with top private practices.
• Join a growing Psychiatry & Behavioral Sciences Department that offers state-of-the-art treatment, including more than 16 clinical services.
• Become a member of a 900-plus-physician, multispecialty group practice that includes more than 100 office locations with over 2,400 affiliated physicians.
• Be part of the Mayo Clinic Care Network; Mayo’s only collaboration of its kind in the Chicago region.
• Obtain academic appointment to The University of Chicago Pritzker School of Medicine if qualified.
• Experience the full range of lifestyles that are uniquely available in the Chicagoland area.

Qualified candidates should submit their CV to: Frederick E. Miller, MD, PhD, Department of Psychiatry & Behavioral Sciences, by contacting:

Sandra Chavez, Physician Recruiter
schavez@northshore.org
(847)663-8649
www.northshore.org/physicianrecruitment
EOE: Race/Color/Religion/Sex/National Origin/Protected Veteran/Disability,
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MARYLAND
Kennedy Krieger Institute is an internationally recognized facility dedicated to improving the lives of children and adolescents with pediatric developmental disabilities through patient care, special education, research and professional training.

Kennedy Krieger’s clinical programs offer an interdisciplinary approach in treatment tailored to the individual needs of each child. Services include over 40 outpatient clinics; neurobehavioral, rehabilitation and pediatric feeding disorders inpatient units; plus several home and community programs providing services to assist families.

The Family Center is an outpatient department that specializes in the assessment and treatment of children and families that have experienced or are at risk for neglect, abuse and violence exposure.

This opportunity is a full-time position at the Department of Psychiatry working in The Family Center at Kennedy Krieger Institute. This position may include a faculty appointment with research opportunities at the Johns Hopkins University School of Medicine Department of Psychiatry, depending upon the candidate’s experience.

This position requires a BE/BC in Child and Adolescent Psychiatry.

*For candidates eligible for faculty appointments: This position provides a mixture of clinical, teaching and research opportunities, dependent on the interests and skills of the faculty member. The Johns Hopkins University School of Medicine faculty rank will be commensurate with experience. There are excellent benefits, including partial college tuition remission for dependents (at any college) and tuition remission for faculty members, spouses and dependents for course work performed at the Johns Hopkins University and the Peabody Institute.

Boating, sandy beaches, mountains and less than an hour away from Washington, D.C. and Pennsylvania. Kennedy provides...

September/October 2015 241
excellent benefits, competitive salaries and this position is an NHSC approved loan repayment site. For more information about loan repayment, see http://nhsc.hrsa.gov/loanrepayment/.

Please apply on-line: https://jobs-kennedykrieger.icims.com/jobs/10986/pediatric-psychiatrist%28family-center%29/job
EOE M/F/Disability/ProtectedVet
Internal Number: 727

UTAH
ACADEMIC CHILD AND ADOLESCENT PSYCHIATRIST—GENERAL OUTPATIENT
Salt Lake City, UT
The Division of Pediatric Behavioral Health in the Department of Pediatrics at the University of Utah is recruiting for an Academic Child and Adolescent Psychiatrist to provide outpatient care for patients referred to the Department of Psychiatry and Behavioral Health at Primary Children’s Hospital (PCH) as an attending physician on the General Outpatient Unit. Clinical activities will be carried out at the Wasatch Canyons Campus of PCH. The psychiatrist will provide on-call coverage by phone during off hours and weekends as a supervisor for crisis workers in the PCH Emergency Department. In addition to clinical service, there is an expectation for academic work, including education, investigation, administration as well as advocacy. This is an incredible opportunity to join a collegial academic environment and work in a children’s hospital ranked as one of the best in the US.

Qualified candidates must have an MD or DO degree and be Board Qualified/Board Certified in Adult and Child and Adolescent Psychiatry. The selected candidate will receive a faculty appointment in the Department of Pediatrics on the Clinical or Tenure track at the academic level commensurate with experience and qualifications.

The University of Utah Health Sciences Center is a patient focused center distinguished by collaboration, excellence, leadership, and Respect. The University of Utah HSC values candidates who are committed to fostering and furthering the culture of compassion, collaboration, innovation, accountability, diversity, integrity, quality, and trust that is integral to the mission of the University of Utah Health Sciences Center.

Qualified candidates must have an MD or DO degree and be Board Qualified/Board Certified in Adult and Child and Adolescent Psychiatry. The selected candidate will receive a faculty appointment in the Department of Pediatrics on the Clinical or Tenure track at the academic level commensurate with experience and qualifications.

CHILD AND ADOLESCENT PSYCHIATRIST—ATTENDING PHYSICIAN, INPATIENT UNIT/OUTPATIENT CLINIC
Salt Lake City, UT
The Division of Pediatric Behavioral Health in the Department of Pediatrics at the University of Utah has several openings for Academic Child and Adolescent Psychiatrists to provide inpatient and outpatient care for patients referred to the Department of Psychiatry and Behavioral Health at Primary Children’s Hospital (PCH) as an attending physician. The psychiatrist will provide on-call weekend coverage, including rounds, as an attending physician on the inpatient unit and on-call coverage by phone during off hours and weekends as a supervisor for crisis workers in the PCH Emergency Department. Clinical activities will be carried out at the Wasatch Canyons Campus of PCH.

In addition to clinical service, there is an expectation for academic work, including education, investigation, administration as well as advocacy. This is an incredible opportunity to join a collegial academic environment and work in a children’s hospital ranked as one of the best in the US.

Qualified candidates must have an MD or DO degree and be Board Qualified/Board Certified in Adult and Child and Adolescent Psychiatry. The selected candidate will receive a faculty appointment in the Department of Pediatrics on the Clinical or Tenure track at the academic level commensurate with experience and qualifications.

The University of Utah and Department of Pediatrics offer an excellent benefits package that includes 20.2% retirement contributions that vest immediately and excellent health care choices. The Department offers an education loan repayment program, departmental research core with mentoring, as well as education and leadership opportunities.

Interested individuals can apply for the position at http://utah.peopleadmin.com/postings/42374. Cover letter and curriculum vitae will be required. For additional information about the position, please contact: D. Richard Martini, MD, at richard.martini@hsc.utah.edu.

The University of Utah is an Equal Opportunity/Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veteran’s preference extended upon request to qualified applicants. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/human-Resources/5-106.html

The University of Utah Health Sciences Center is a patient focused center distinguished by collaboration, excellence, leadership, and Respect. The University of Utah HSC values candidates who are committed to fostering and furthering the culture of compassion, collaboration, innovation, accountability, diversity, integrity, quality, and trust that is integral to the mission of the University of Utah Health Sciences Center.

Qualified candidates must have an MD or DO degree and be Board Qualified/Board Certified in Adult and Child and Adolescent Psychiatry. The selected candidate will receive a faculty appointment in the Department of Pediatrics on the Clinical or Tenure track at the academic level commensurate with experience and qualifications.

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