SAVE THE DATE!

AACAP's
63rd ANNUAL MEETING
OCTOBER 24–29, 2016 | NEW YORK, NY

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Photo Credit: Fred Seligman, MD
AACAP Legislative Conference and Assembly Meeting
April 14-16, 2016

AACAP’s 2016 Legislative Conference and Assembly Meeting will take place in Washington, DC, from April 14-16, 2016. Join us for both events to advocate for children’s mental health.

AACAP Legislative Conference

On April 14 and 15, AACAP’s Government Affairs team will teach you about the legislative process, provide you with advocacy materials to help you develop and deliver the most impactful messages, and schedule your meetings with legislators on Capitol Hill. Join us as we advocate for children’s mental health and make your voice heard!

Visit www.aacap.org/LegislativeConference for more information or contact Zachary Kahan, Legislative & PAC Coordinator, at zkahan@aacap.org or 202-587-9669.

AACAP Assembly Meeting

On April 16, AACAP’s Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.

Visit www.aacap.org/Assembly for more information or contact Megan Levy, Executive Office Coordinator, at mlevy@aacap.org or 202-966-1994.
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**Cover:** AACAP’s Assembly, took the stairs of the Convention Center – standing tall and proud during the 62nd Annual Meeting in San Antonio, TX. Once again, our fantastic member photographer extraordinaire, **Fred Seligman, MD**, was gracious and kind to once again act as AACAP’s official meeting photographer!
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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PRESIDENT’S MESSAGE

Advocating for Advocacy

Gregory K. Fritz, MD

This issue marks my first President’s Message column for AACAP News, and I must admit, I am excited about the opportunity to share my thoughts with my colleagues in AACAP on a regular basis. One of the things that most attracts me to leadership in our organization is the potential to grapple with and possibly influence policies that impact the mental health of children, adolescents, and families. Many of us have become increasingly frustrated by how difficult it is to do the right thing for children, even though we know more now in every realm of child and adolescent psychiatry than we did two decades ago. What typically gets in the way is unhelpful policy. It often seems that whichever way we turn, there is a policy in place that limits our effectiveness. Governmental policy, insurance policy, regulatory policy, institutional policy—too frequently they say, “You can’t get there from here.” The constructive approach to these frustrations is advocacy, which I believe should be a core component of our professional identity as child and adolescent psychiatrists.

There are secondary benefits to advocacy as well. Effective advocacy entails a degree of visibility, which can generate support for fundraising programs. It also provides a model for trainees and an opportunity for their involvement. Day-to-day advocacy work often builds an influential network that can be mobilized in times of crisis. Effective advocacy has several components that need to proceed concurrently: visibility, relationships, product-producing work, and fundraising. Visibility requires more than stature in our professional and scientific organizations. It means visibility within our community—local, regional, or national—that enhances our ability to be effective advocates. Part of this stems from making ourselves available to newspapers, magazines, television, radio, and online media. Reluctance, suspicion, elitism, and anxiety (all too common reactions when psychiatrists are confronted with media requests) work against increasing our visibility in the world.

Just as all politics are local, all relationships are personal. Individual relationships need to be cultivated with leaders of consumer or patient groups, politicians, heads of agencies, and reporters. We can develop these relationships by initiating meetings, arranging tours, inviting individuals to lunch, etc. Some people are more comfortable in a one-on-one setting than a larger, public forum; this approach is one of the most effective in terms of affecting policy.

Advocacy is not just public relations and schmoozing. We must be willing to contribute our knowledge, evaluation skills, organizational and clinical expertise, and the critical ability to put a human face on an otherwise arcane policy. The effective advocate is willing to chair the committee, write the report, and provide the background support—in short, to produce a product that few others are willing or able to do. Fortunately, AACAP members interested in increasing their advocacy activities do not have to start at square one; we have access to great resources and staff in the Government Affairs Department for ready consultation. My plan for the two years of my presidency is to devote some of these presidential columns to policy issues that challenge every one of us to step up our game in the realm of child mental health advocacy. In addition, I intend to share my personal commentaries on topics of particular relevance to child psychiatrists through other communications channels. I am interested to hear your opinions and feedback as we go forward.

Gregory K. Fritz, MD
Happy New Year from Austin, Texas! New years bring changes, and it is with mixed feelings that I will be resigning from my role as columns editor for AACAP News. I have worked with an amazing team of people and learned so much about the editorial process with an eye for truly good writing.

I have worked hard to develop the columns section over the past five years to include many thoughtful changes, all in an effort to better fit the mission of this publication. Some of these changes include:

- Transitioning from single-authored columns to multiple-authored columns, in hopes of gaining a wider perspective from the entire Academy body
- Encouraging an open invitation to anyone in the Academy to write for this publication; we all have a voice that needs to be heard
- Recruiting an amazing cadre of specific coordinators for each column, who help solicit and vet the submissions we receive
- Establishing a new Systems of Care column that will bring light to what I believe is the future of child and adolescent psychiatry, especially as our work shortage continues and the population of mentally-ill youth increases
- Establishing a new Acute Care Column to cover topics pertinent to those who work in crisis settings such as the emergency room, acute psychiatric hospitals, residential treatment centers, and assertive community programs
- Establishing a new Psychopharmacology Corner that provides useful treatment pearls to clinicians on common as well as controversial maladies
- Creating connections with the child and adolescent psychiatric community internationally by collaborating and learning from their experiences, by giving them a voice in AACAP News

It is with great pleasure that I announce that this editorial position will be left in the good hands of my colleague Neera Ghaziuddin, MD. Future correspondence may be sent to her at neerag@med.umich.edu.

With all this said, I would like to depart with an encouragement to my fellow fighters and healers in the field. I have felt rewarded by my work at times, but also disillusioned. From my experience as an early-career psychiatrist, I believe that disillusionment is inevitable and happens to the best of us, especially those with skin in the game. So keep fighting for the cause, for the community, and the individual patients we see day-in and day-out. We are truly needed.

Dr. Dunham is an early-career child and adolescent psychiatrist from Austin, Texas. She is pictured here with her twin sons. She works in a community-based, integrated care model as a consultant to the pediatricians at the new University of Texas Dell Medical School Pediatric Residency Program. In addition, she lectures on public child mental health for child fellows in training. She can be reached at jeandunham@gmail.com.
JERRY M. WIENER RESIDENT MEMBER TO COUNCIL

Mentorship at the Annual Meeting: 
Recent Events and Becoming Involved

At AACAP’s 63rd Annual Meeting in San Antonio, Texas, I was excited from day one. The reason was simple—our first event was the Life Members Mentoring event that was held on Tuesday, October 27, at 4:30 PM. I arrived 30 minutes early to prepare and meet my colleagues from the Medical Students and Residents Committee. To my surprise, Perry Bach, MD, and Fred Volkmar, MD, were already there chatting and ready to mentor. Dr. Volkmar immediately began speaking with mentees, imparting his life wisdom and clinical pearls related to the diagnosis and assessment of children affected by autism spectrum disorder (ASD). Drs. Volkmar and Bach also answered many questions—while injecting humor throughout. We were joined by John Schowalter, MD, Martin Drell, MD, and Laurence Greenhill, MD, who quickly opened conversations with mentees as well. At the tables I visited, Drs. Drell and Schowalter made sure to create a carefree and a laid back atmosphere with a great raft of humor. Mentor biographies were handed out to all, approximately 90 to 100 attendees, and we, the trainees, entered and were plugged into the proverbial chargers—the Life Members, who refer to themselves as the Owls.

This brings up important questions. How are these events organized, who organizes them, and when does this occur? The answer is quite simple. Mentees (trainees) work out the logistics with mentors, inviting them to speak, and planning collaboratively with each other over conference calls. Many of these trainees are members on the Committee for Medical Students and Residents, serving on the subcommittees for the Career Development Forum, the Mentorship Program, and working as liaisons with Life Members for the event described and other similar events.

“How are these events organized, who organizes them, and when does this occur?”

Every year, I learn more through informal conversations with Life Members, training directors, and senior colleagues who share and give advice about careers and life in general. All of us in training appreciate both types of advice and definitely recommend that residents and fellows take advantage of these events where there are ample opportunities to meet the training directors and leaders throughout our field. Such opportunities marked by generous collegiality of child and adolescent psychiatrists stand in vivid contrast to other fields of medicine.

In retrospect, the early arrival of our Owl mentors is not surprising at all, but serves as one small example of their character as teachers—a strong desire to inspire, welcome, impart knowledge—and through all of these attributes, to lead. In the later life stages initiated by Erik Erikson, most notably, generativity versus stagnation transitioning into ego identity, helping others may be thought of as a natural evolution. I feel this is a form of that generosity. My colleagues and I have been moved by their unusual kindness and willingness to engage and advise trainees, which exceeds any “age-expected norm.”

In conclusion, we are all extremely thankful for the time, effort, and wisdom of our mentors—from attendings, chiefs of service, training directors, to those who trained them all—the Life Members. If there are any questions about how to become more involved in organizing mentorship events, which events to attend, or learning more about the Committee for Medical Students and Residents for advice about making the most out of the AACAP Annual Meeting as a trainee, please do not hesitate to contact me at roberto.aaron41@gmail.com.

Dr. Roberto is a child and adolescent psychiatry fellow at Harvard Medical School and Boston Children’s Hospital.

HONOR YOUR MENTOR!

Whether you’re a medical student, resident, researcher, practitioner, or retired, someone made a significant impact on your career. We’re asking all of you to take the time to honor your mentor and tell others why they were important to you and how they influenced your life. In 100 words or fewer, tell us about your mentor. Please include your name and a short testimonial or anecdote. E-mail submissions to communications@aacap.org by February 10, 2016.
What is “Traumatically Skewed Intersubjectivity”? Infant Psychiatry Paper Wins 2015 AACAP Rieger Psychodynamic Psychotherapy Award

Daniel Schechter, MD, infant, child, adolescent, and adult psychiatrist and psychoanalyst, who is currently senior lecturer in Psychiatry at the University of Geneva, won the 2015 AACAP Charlotte and Norbert Rieger Psychodynamic Psychotherapy Award for his paper entitled “Traumatically Skewed Intersubjectivity.” The paper will be published in an upcoming issue of Psychoanalytic Inquiry, honoring the work of the late Daniel Stern, MD, pioneer in infant psychiatry. The paper also has been awarded the Hayman Prize for Published Work on Traumatized Children and Adults by the International Psychoanalytical Association.

Even before starting medical school, as a volunteer in a therapeutic nursery school, Schechter noted that mothers who had been exposed to maltreatment and violence as children tended to describe their infants and toddlers in unimaginable, disturbing ways. He recollects one mother who said of her daughter, “she is a mean baby…she likes to hit her mommy.” The infant was only two months old! This mother went on, “you see the way she is holding her fist, that’s the way she held it in her womb and when she was born—she’s a boxer like her dad and she’s going to kill someone someday, like he did.” Daniel Schechter had expected a mother to tell him how good-looking, smart, and wonderful her baby was. What would be the impact of the mother’s intensely negative image on that child growing up?

The work of Selma Fraiberg in “Ghosts in the Nursery” pointed to the ways in which the traumatized parent’s experiences contribute to the intergenerational cycles of abuse, violence, and related trauma. Alicia Lieberman extended these ideas further in her papers on negative attributions and the importance of positive past attachments, or “Angels in the Nursery,” that can mitigate those toxic effects. Schechter realized that the question of how traumatic experience, in the context of attachment, affects a parent’s perception of her/his child had not been fully studied empirically and took this topic as his focus of study during his research fellowship at Columbia University in the late 1990s. Clinical material from that project was the basis of Schechter’s 2010 Rieger Award winning paper “When Parenting Becomes Unthinkable: Intervening With Traumatized Parents and Their Toddlers” published in the Journal of the American Academy of Child and Adolescent Psychiatry. Even before starting medical school, as a volunteer in a therapeutic nursery school, Schechter noted that mothers who had been exposed to maltreatment and violence as children tended to describe their infants and toddlers in unimaginable, disturbing ways. He recollects one mother who said of her daughter, “she is a mean baby…she likes to hit her mommy.” The infant was only two months old! This mother went on, “you see the way she is holding her fist, that’s the way she held it in her womb and when she was born—she’s a boxer like her dad and she’s going to kill someone someday, like he did.” Daniel Schechter had expected a mother to tell him how good-looking, smart, and wonderful her baby was. What would be the impact of the mother’s intensely negative image on that child growing up?

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In his current paper on “Traumatically Skewed Intersubjectivity,” Schechter draws on his work at the University of Geneva Hospitals in Switzerland, where he is currently deputy chief of Service and director of the Consult-Liaison Unit in the Division of Child and Adolescent Psychiatry. Dr. Schechter is also in charge of parent-infant research in the Division. The focus of this research is maternal posttraumatic stress disorder and its impact on caregiving and on the social-emotional development of infants and young children. Particularly, Dr. Daniel Schechter’s work traced the development of intersubjectivity, defined as the sharing of subjective states by two individuals, starting out with simple imitation of social communication during the development of primary intersubjectivity based on the caregiver’s mirroring of the infant over the first two-to-three months of life. The pair develop a mutual regulation of emotion and arousal within the context of caregiver-child attachment as a building block of the child’s capacity for emotional regulation.

“The focus of this research is maternal posttraumatic stress disorder and social-emotional development of infants and young children.”

Schechter is asking what sort of past difficulties result in unhelpful responses in the “haunted” parent, which may be associated with her personal experiences and/or attributes in her child. Because the child has no way of knowing that these responses stem from the parents’ past, the child struggles to understand them as representing dangers in the present. Thus, these traumatic responses may hamper the child’s ability to form consistent and predictable secure emotional connection with the “haunted” caregiver.

Daniel Stern’s work traced the development of intersubjectivity, defined as the sharing of subjective states by two individuals, starting out with simple imitation of social communication during the development of primary intersubjectivity based on the caregiver’s mirroring of the infant over the first two-to-three months of life. The pair develop a mutual regulation of emotion and arousal within the context of caregiver-child attachment as a building block of the child’s capacity for emotional regulation.
Thus, until the brain is physically able to attend jointly to a focus, a capacity that usually develops at nine-to-ten months, the child, as far as can be observed, does not attempt to label and, thus, to make sense of caregiver's affective communications, but rather accepts them as they come and responds primarily with imitation or reciprocation.

It is only when, at about nine-to-ten months, the child begins to gesture and point so as to share a joint focus of attention with the caregiver, that the child, when observing the caregiver, begins to attempt to take the caregiver's point of view and in a rudimentary way question what is going on in her/his mind. Ideally, the caregiver has already been modeling from birth, with gestures and verbalizations, that she/he sees the infant as having a separate subjective experience, in essence a mind of its own. Hopefully, the caregiver has demonstrated both embodied and explicitly verbalized efforts to understand what is going on in that infant's mind. Additionally, the child needs a caregiver's consistent, predictable and sensitive participation in thinking about and translating in a developmentally appropriate way what is going on in her/his own mind; otherwise the child can misread the caregiver's intentions and become confused and feel lost. This secondary intersubjectivity is a cornerstone of the development of the theory of mind and later mentalizing function—another hidden regulator within the context of attachment, in place by five years.

Secondary intersubjectivity is a term applied by infant researchers to the period at the end of the first year of life, when the infant begins to reference the context of the shared, subjective, emotional experience as relevant to the caregiver's reaction. When the caregiver, triggered by a behavior of the infant or perhaps by some entirely external trigger, responds with emotions and behavior that are relevant to her/his earlier life trauma. However, the infant is unable to fathom or intuit this earlier experience of the caregiver and is unable to use these processes to make sense of the caregiver's arousal and enactments. Thus, the intersubjectivity becomes skewed, putting the infant at risk for significant distortions in emotion regulation and theory of mind.

In his prize-winning paper, Schechter describes his clinical observations on how children, by the circumstances of their relationship with a traumatized parent, enter their parents' traumatic world, while struggling to make sense of the parents' perceptions and behaviors in order to fulfill the child's developmental need for intersubjectivity.

The resulting interactions often have a traumatic quality for an observer, such as when a mother threw away all of her child's teddy bears and pillows after a flashback in which she recalled having been smothered as a child during repeated rapes by her uncle. And yet, the traumatic reaction of the mother, as she, in agitation and without explanation or warning, hurled her daughter's favorite stuffed animals into the trash bin, cannot be thought of or felt by her 17-month-old daughter as “the same trauma” to which the mother's perceptions and behaviors refer. Tragically, this daughter, who knows nothing of her mother's previous trauma, and sees only her mother's terror and experiences the trauma irrationally inflicted upon her by the loss of her own beloved toys.

Schechter describes how he was able to help this and other mothers take their child's perspective and vice versa, facilitated by his taking both the mother's and child's perspective as an observing third person in a psychotherapeutic setting, with positive results for both. Interestingly, these positive results can be surprisingly rapidly initiated even if they take a longer time to consolidate and maintain. He surmises that this is likely due to the increased plasticity during this fast-paced developmental period, the mother's desire for something new, and to do differently with her own child than what had been done to her.

Dr. Ritvo is on the faculty of the Baltimore-Washington Psychoanalytic Institute and Children's National Medical Center, and has a private practice in Kensington, MD. She may be reached at rzrmd@comcast.net.

The AACAP Rieger Psychodynamic Psychotherapy Award
Given each year in recognition of the best published or unpublished paper, written by an AACAP member, that uses a psychodynamic framework and presents:

1) clinical material demonstrating the inner life of an infant, child, or adolescent, or

2) research material that promotes psychodynamic principles in order to illustrate the paper's idea or hypothesis.

Papers must be submitted to the AACAP Clinical Practice Department by May 2, 2016. (clinical@aacap.org)
DIVERSITY AND CULTURE

“You Are My Guardian Angel”

Tania Nadeem

“Y ou are my guardian angel!” That dialogue generally sums up how I see the quality of patient interaction in Pakistan. Those who are seeking help are usually very respectful towards doctors irrespective of the specialty. Improvement in symptoms is often seen as a “miracle.” This reverence that a patient and the family bestow upon a doctor is very representative of patient-doctor interactions in Pakistan, as long as you as the doctor treat the patient with respect and take time to listen to them. In my view, this feeling of satisfaction that a doctor gets from such interactions is much more fulfilling compared to success based on the amount of money one may earn.

I lived in the United States for seven years. I completed my four years of training in general psychiatry at the University of Texas, Houston, and then did two years of child and adolescent psychiatry at the Menninger Department of Psychiatry, Baylor College of Medicine. I continued to work in an acute care adult inpatient setting in Houston until my return to Karachi, Pakistan, in December 2010.

The most concerning aspect of the move back had been the law and order situation of Karachi, a cosmopolitan city of more than 20 million people. The problems Karachi faces are a mix of muggings, kidnappings, robberies, and strike calls, along with terrorism in the form of bomb blasts. The most nerve-wrecking problem is the terrorist threat to schools.

A reader may wonder about my move back to Pakistan amidst a variety of obvious hardships. However, my Karachi also represents resilience, energy, and love. This move was primarily driven by my desire to see my children grow up amidst their grandparents and enjoying the festivities of Eid—the Festival of Breaking the Fast—the way one can only do this in Pakistan, eating a variety of foods available here, and giving them the opportunity to study at my old school.

Working in this city in the background of the aforementioned environment has its own pros and cons. My children have never been happier and I have never had a better social life but I continue to fear being mugged while driving.

Working at the Aga Khan University Hospital is very similar to the working environment in the United States. I see adult and child patients, and have the fair mix of depressed wives, autism, ADHD, and parenting issues. Conversion disorder in children and many anxiety disorders due to academic or environmental stressors are diagnoses that I was less frequently exposed to in the United States. Lastly, there is posttraumatic stress disorder (PTSD) among individuals exposed to bomb blasts, those who have lost loved ones during muggings gone wrong, or individuals who have just returned after being kidnapped. My training in the United States did not prepare me for such cases, and it was a steep learning curve as I started my work here. A supportive chair and department was greatly helpful during my early days.

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Some novel concepts that I have realized are that the doctor-patient boundaries learnt in the United States cannot remain as stringent in an environment where there are no support services and patients might not be able to afford a doctor or access a doctor as regularly as needed. I have had to allow means of communication that account for all these limitations and have learned that some patients prefer that I, as their doctor, make the final decisions about treatment rather than giving them multiple choices. When counseling women in abusive relationships, remaining non-committal might not be an option.

The most daunting part of working in Pakistan is the lack of social services for rehabilitation purposes and implementation of laws to protect patients. When you work here, you are not just the doctor; rather you end up being the social worker and the judge. In cases of sexual abuse, you have to act without any provisions of an agency such as the child protective services. You have to ensure that the family works with you and removes the offender from the environment. You also have to live with the troubling fact that the offender does not go to jail.

In such circumstances, when you fail, it feels terrible, but when you succeed the emotional rewards are incomparable. Recently, an old patient of mine sent me a video of her child’s graduation; this is my reward, when your patients share their joy with you. For me, I am daily reminded why I have chosen to become a doctor. And I am grateful for the decisions I have made!

Dr. Nadeem is a Diplomat of ABPN in general and child and adolescent psychiatry, and an assistant professor in the Department of Psychiatry at Aga Khan University Hospital in Karachi, Pakistan. She may be reached at tania.nadeem@aku.edu.
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.

AACAP’s Nominating Committee is presently soliciting names for nominations for two Councilor-at-Large positions. Nominations must be received before February 1, 2016 and should be emailed to executive@aacap.org. The Nominating Committee includes:

Paramjit T. Joshi, MD, Nominating Committee Chair
Children’s National Medical Center
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JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry promoting the development of translational skills and publication as education. The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences. We work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles.

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Traditional School Alternatives: Homeschooling

While a desire to provide religious or moral instruction may have once been a top reason to homeschool, these reasons have been surpassed by concerns about school environment, dissatisfaction with academic instruction in other schools, and reasons such as family time, finances, travel, and distance. In addition, families are increasingly choosing homeschool because of their children’s physical or mental health problems.”

Families have multiple reasons for choosing to homeschool their children. While a desire to provide religious or moral instruction may have once been a top reason to homeschool, these reasons have been surpassed by concerns about school environment, dissatisfaction with academic instruction in other schools, and reasons such as family time, finances, travel, and distance. In addition, families are increasingly choosing homeschool because of their child’s physical or mental health problems (OII-USDE).

Homeschooling differs from homebound in that a homeschooled child is not enrolled in a public school and schooling is the responsibility of the parents. Homebound children have a short-term reason they cannot attend school (e.g., immunosuppression) and are taught by a teacher provided by the public school in which the child remains enrolled and the teacher visits the child at home.

Similarly, there are multiple styles of homeschooling. Many families provide school-at-home by purchasing a boxed curriculum with books and other materials ready-made based on religion (Abeka), ideology (Ron Paul Curriculum), or secular (Timberdoodle). Others provide “unschooling” by allowing the child to lead the learning through interests developed in everyday life; a curriculum based on a specific method such as classical, Charlotte Mason, Montessori, or Waldorf; or online courses provided by public and private entities (homeschool.com). A family’s choice of curriculum will likely reflect its values and beliefs and the reasons for choosing homeschooling for the child.

Some families choose an eclectic approach and join a homeschooling co-op or other group such as One Day Academy (onedayacademy.com) that provides for group learning, particularly for topics families feel less inclined to teach themselves, often science and math. Homeschooling co-ops also often hold social events that encourage interaction between children (Metropolitan Austin Interactive Network).

Homeschooling regulations differ from state to state. In Texas, families are required to maintain a written curriculum and teach grammar, reading, math, spelling, and civics in a bona fide fashion, though no oversight of the process is required (Terry 2011). In Massachusetts, a more stringent requirement is in place. Families must request approval from their local school districts who are allowed to request information about the qualifications of the teachers, the nature of the curriculum, and examples of teaching materials (Massachusetts Home Learning Association). The homeschooling advocacy organization, the Homeschool Legal Defense Association (HSLDA), offers interpretation of homeschooling laws state-by-state and advocates for homeschooling.

As a child and adolescent psychiatrist, you have probably been asked your opinion on homeschooling for one of...
your patients. Parents often want input or approval from professionals and are often conflicted on homeschooling the child. Data on effectiveness of homeschooling has been elusive (Murphy 2014, Lubienski et al. 2013) but certainly for individual students, homeschooling may be preferable to ongoing misery and lack of success in a public school environment not compatible with the child’s problems. Parents need to know that the decision is ultimately theirs. They need to be encouraged to consider what their goals are for homeschooling their child and how they would accomplish the schooling, taking into account the independence level of the child. They need to consider the parent-child relationship if they intend to provide the instruction themselves. And, especially for children who have developmental or emotional problems, parents must consider how they will be providing social contact for their homeschooled child. Homeschooling is a social movement that has grown in numbers and visibility over the last 20 years. As a result, homeschoolers will make up an increasing number of the patients we see in child and adolescent psychiatry. Becoming and remaining familiar with homeschool processes and findings will allow us to provide better care for our homeschooled patients.

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Timberdoodle. www.timberdoodle.com

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Drawing upon our community mental health providers’ expertise, journalists with whom we have cultivated relationships, advocates in state government and the private sector, and experienced stakeholders, particularly reaching out to younger, passionate, early career individuals, the Minnesota Society of Child and Adolescent Psychiatry (MSCAP) applied for and received a grant from AACAP to co-host the MSCAP-MACMH-NAMI Minnesota Community of Experts Summit on November 21, 2015. The purpose of the event was to engage and empower stakeholders to collaborate to take ownership and leadership of the Minnesota children’s mental health system. The Summit took place at the New Brighton Community Center.

By partnering with the Minnesota Association for Children’s Mental Health and NAMI Minnesota, MSCAP organizers brought together the state’s best known advocates to share training resources that informed all stakeholders in their efforts to build a larger coalition of change-makers. Participants heard how the mental health community came together in St. Paul, Minnesota, to name and fight stigma when a new crisis residential treatment center was blocked from going into a neighborhood and serving its citizens. The agenda also offered educational presentations on the Minnesota Mental Health system, a review of the 2015 legislative session, and the citizen advocate perspective on current gaps; as well as a training session on basic advocacy. The Summit successfully attracted experts in the areas of telemedicine, marijuana and the adolescent brain, and Minnesota’s child Protection system and its link to mental health services who gave updates in their area of interest, followed by small group discussions and an interactive planning session to strategize how best to advocate as a community of experts. This was followed by a reporters’ roundtable to learn about the press’ role in communicating needs and concerns to the public. The Summit ended with a summary session to develop final priorities.

The Minnesota Community of Experts Summit was a coalition builder and, hopefully, a catalyst for change in the immediate future. For more information on the Summit and the resulting strategies and priorities, please contact MSCAP at www.mnpsychsoc.org or call 651-407-1873 with your questions.
The Child and Adolescent Psychiatrist as a Part of a Child Death Review Team

A child’s death challenges our fundamental sense of fairness and justice. It makes a powerful emotional impact. Somehow we seek to give it meaning, to make it comprehensible.

Physicians are familiar with the autopsy. We learn from the dead to preserve life in the future. In the late 1970s, Michael Durphy, MD, a child and adolescent psychiatrist in Los Angeles, witnessed a child’s death. Deeply affected, he realized that “dissecting” that event might be a tool to bring agencies and people together to learn and improve other children’s wellbeing.

By the early 1980s, he had overcome numerous administrative and bureaucratic issues, and established the first multi-disciplinary child death review team (DRT). Our county was impressed with his efforts; we followed his lead. I was at the time the medical director for a child/adolescent psychiatric inpatient unit, part of a non-profit hospital with a strong community service tradition. My administration allowed me to participate in the DRT as part of my job.

We began with members from public health, pediatrics, law enforcement, the district attorney’s office, adult and child probation, child abuse advocacy, an investigator from the medical examiner’s office, education, mental health, child psychiatry (me), hospital social work, and two representatives from social services. Over the past twenty years, the team has broadened. We added a neonatologist, a divorce and custody court representative, drug and alcohol services, the pediatrician doing emergency screenings for family services, a representative from emergency medical response, a deputy medical examiner, a retired minister, the chief of the county’s maternal and child health program, and a representative from the county executive’s office.

Los Angeles County has 10 million people, and that team took an epidemiological approach. In Santa Clara County, we have taken a case-centered approach. We review each child death not caused by a clearly medical condition. We meet one full morning a month and discuss about 50 cases a year. Before each meeting, the team coordinator—a public health nurse—tells the county agencies the child’s name, date of birth, and parent. Team members do a “record check” to determine whether that family had previous contact with their agency.

We do not talk with the dead child’s family.

Every presentation starts with the deputy medical examiner presenting a brief factual narrative of the preliminary information the investigator has gathered from those involved, a description of the death scene, and sometimes the body. The physical autopsy, as well as toxicological, and bacterial and viral studies may be included.

After the presentation, each agency presents any information it has. We then discuss the case with several goals in mind.

First, we want to clarify the facts for forensic/legal purposes—in effect, we are the medical examiner’s consultant. Second, we want to determine if other children in the home are at risk. Third, perhaps most importantly, we want to learn if we can prevent deaths in the future.

Dr. Durphy predicted that one important consequence of team meetings would be increased understanding and cooperation between different disciplines and groups. Governmental entities tend to become insular and defensive when confronted, especially in a public format. In the team setting, members can say, “We dropped the ball on this…” without fearing repercussions while getting feedback about areas within the agency—and within systems—that could be improved.

Becoming a team forced us to think about the rules and responsibilities across agencies. Understanding the different rules each agency worked under, and thus how each looked at a problematic situation, made it easier for the groups to work cooperatively. The team members took that awareness back to their agencies and serve as informal educators.

The question we keep asking is, “What would it take to prevent this death in the future?” Of course, we cannot eliminate misery, strife, poverty, and drug abuse. Still, in numerous situations, small improvements could prevent people from “falling through the cracks.” In others, new or better services could help. For instance, schools and law enforcement began paying more attention to the traffic arrangements when parents drop off and pick up their children at school. Hospitals are doing better at training parents in “back to sleep” arrangements that reduce deaths due to Sudden Infant Death Syndrome (SIDS). Schools are trying to better identify suicidal youth. We have learned more about the hazards of co-sleeping and have been teaching the community about accidental suffocation. Poor families are provided car seats for infants.

Sometimes, this has led to formal inter-agency cooperation protocols; police, social services, the district attorney and the medical examiner cooperate in the immediate crime scene investigation.

We have stimulated larger public health efforts. A sustained, educational approach has led to major drops in infant mortality, largely based on a drop in the number of children killed in auto
accidents (because they are strapped into car seats!) and a significant drop in SIDS cases. These steps do not come specifically from a single team. They come from knowledge that develops from over 200 DRT teams in the United States and eleven foreign countries.

But death review has psychological costs. Despite the pathologist’s warning before showing slides of haunting images, my eyes remain open. Sometimes the images stay seared in my memory and appear in my dreams. For a time, I found it difficult to move back and forth between the orderly, gentle middle class world I usually function in and the harsh world I see once a month, where violence, gore, and tragedy are commonplace.

I became more cautious and protective towards my family. In my therapy work, I find myself talking more with teens about wearing helmets when skateboarding, about learning to be “street smart” around drugs and alcohol, and how to be wise about risk taking.

Team members are experienced professionals who have faced the psychological issues that go along with their work. Some get a little antsy meeting a psychiatrist. I try not to psychologize and try to give straightforward answers to questions. Occasionally, someone tells some joke about weird shrinks; I laugh with them. Later, they start talking with me about their cousin’s child who is autistic, or their grandson who has attention-deficit/hyperactivity disorder.

Sometimes the team turns to me to make a youth’s or parents’ behavior intelligible—how could a woman with a post-partum psychotic depression murder her child? I am the expert on teen suicides. As such, for many years, if a child had been in treatment, and killed himself, I would talk with the clinician. I tried to both learn what went on, and to support the clinician. HIPAA rules have made this communication much more difficult, if not impossible.

Suicide prevention is still in its infancy. Most (but certainly not all) of the time we can figure out what happened and get some good ideas as to why it happened. Figuring out how to prevent suicides is much more difficult. This is a major ongoing area of research.

Once a month, I am forced to face a dark side of life I would prefer to deny exists. Still, I feel that I am a better doctor, a better therapist, and live in a better community as the result of the effort.

Dr. Saul Wasserman is an emeritus clinical associate professor of Child Psychiatry at Stanford University. He was for twenty years the director of a child/adolescent psych inpatient unit in San Jose. He has an ongoing interest in trauma, child abuse, and foster care.
Recovery in Rwanda

Marcialee Ledbetter, MD, MPH

Early in my career at the University of Chicago, I saw patients who were victims and sometimes perpetrators of gang violence on Chicago’s south side and developed an interest in trauma work. When I moved back to my native Oklahoma, my interest in trauma expanded as I began to focus on children in the foster care system. So when, in 2011, I had the opportunity to participate in a People-to-People Mental Health Delegation to Rwanda led by Dr. Nada Stotland, I jumped at the chance. The trip was to focus on the genocide of nearly one million Tutsis and moderate Hutus in 1994 and the subsequent recovery efforts.

When we arrived in Rwanda, we were struck by the green, lush beauty of “The Land of a Thousand Hills.” Against this bucolic backdrop, we began to learn of brutal horrors inflicted during the genocide. The stories we heard were not unexpected, but were still always shocking and unsettling. A section of the Kigali Genocide Memorial Center detailed the lives and deaths of some of the Rwandan children killed in the genocide, often including heart breaking stories of their dreams for the future. After learning other stories of how some were tortured before being killed, I was unsettled to find myself relieved to read some were “only” shot. I found the Memorial overwhelming but the most remarkable thing in the entire museum was how brutally honest the exhibits were about how the genocide came to be in the first place. I admired the great courage it must have taken for the Rwandans to lay bare their own and others’ transgressions, including propaganda such as the Hutu’s Ten Commandments, the role of colonial rule, the role of the Catholic Church, and how the United Nations and the world turned a blind eye to the slaughter.

For many of us, visiting Nyamata Church in the Bugasera region was the most difficult experience. Ten thousand people were packed in the church seeking refuge from the violence – there they were killed. A banner now hangs above the church’s main entrance that says in Kinyarwanda, “If you had known me, and you had really known yourself, you would not have killed me.” On the benches of the church lie the clothes and possessions of the victims with bloodstains still visible in the sanctuary; behind the church is a catacomb of their bones. The feverish slaughter within the country meant that anyone who protected a Tutsi or even protested the killings risked being killed themselves, which made the stories of heroes all the more meaningful.

The second part of the trip centered on the country’s remarkable recovery. In the 21 years since the genocide, Rwanda has made impressive gains with its economy, health, education, and overall stability. We saw organizations devoted to the care of women and children, learned of orphanages developed in the genocide’s aftermath, and the many government interventions. The government determined that for a true recovery to occur, justice proceedings had to include the people and the opportunity for confession and apology. The Gacaca (pronounced ga-CHA-cha) Courts, a form of community justice in which perpetrators were required to confess their crimes to their victims’ families, were a key element in the recovery. Because the number of perpetrators was huge, this process, literally translated as “justice in the grass,” was felt to be necessary. Those who did not acknowledge their misdeeds received harsher sentences. The leaders encouraged citizens to consider themselves Rwandan instead of Tutsi or Hutu. They focused on economic development and improving healthcare and education. In the southern part of Rwanda, where the genocide was the worst, we saw a small community rebuilding itself with microlending, education, and commerce. In the town of Gashora, we encountered a joyful group of women in a cooperative business who sang for us and sold us woven products.

Personally, I was delighted to learn that I had happened to purchase multiple creations from one of the more elderly women present. She was beaming from ear to ear and I was touched and embarrassed to see how much my choice of purchases meant to her. A theme in the recovery that we saw in many places was the use of dance and music. On one delightful morning, we were charmed by a talented group of young boys at Enfante de Dieu orphanage who performed for us a traditional warrior dance with drums. In every instance, we saw how important community and connection were for recovery.

Nearly four years later, as I reflect on lessons learned, I realize how much that trip broadened and deepened my understanding of the causes and treatments for trauma. I learned the tremendous importance of the community both in perpetrating and recovering from horrors. I am impressed with how crucial it is to be honest about the factors contributing to trauma; from this information comes the understanding of how to prevent genocide in the future. This was especially striking to me as I recalled the Murrah Bombing Memorial in my own hometown of Oklahoma City (OKC). While the memorial in OKC is moving, beautiful, and meaningful, it certainly makes no attempt to understand the seeds of that horrible act. I was struck by the interconnectedness in the world and mortified to realize how we Americans focused on the OJ Simpson case while Rwandans were being slaughtered.

As Dr. Bessel Van der Kolk states at the end of The Body Keeps the Score, continued on page 19
A Q&A About Improving Access to Care Through New Credential Process Concierge Service at Cigna

■ Stuart Lustig, MD, and Healthcare Access and Economics Committee

AACAP continues to explore new ways to improve access for children and adolescents in need of mental health services. Critical to this effort is ensuring that those families seeking care have access to as many child and adolescent psychiatrists (CAPs) in health plans as possible. AACAP’s Healthcare Access and Economics Committee (HCAE) is tasked with facilitating this objective.

Over the years, many CAPs have expressed their concerns regarding joining plans, in particular citing troubles complying with health plans’ credentialing processes. Following up on these concerns, the HCAE Committee has approached health plans to look into solutions.

One major health plan, Cigna, has created a concierge program to help members join the plan and to expedite the credentialing process. AACAP News had the opportunity to speak with AACAP member Stuart Lustig, MD, the lead medical director for Child and Adolescent Care at Cigna Behavioral Health regarding this new concierge program:

AACAP: What prompted the review of Cigna’s provider credentialing policies?

Dr. Lustig: We share AACAP’s concern about the significant lack of access for children and adolescents, 20% of whom have a psychiatric illness within a given year. However, the United States has less than one child psychiatrist for every 10,000 children. Clinicians are really busy, and we understand that joining an insurance company to increase access for patients who cannot pay out of pocket can seem administratively daunting. When I attended AACAP’s Healthcare Access and Economics Committee Meeting at the 2014 AACAP Annual Meeting, Alan Axelson, MD, Ronald Szabat, Director, Government Affairs and Clinical Practice, and others indicated that reducing the administrative burden of getting credentialing would help providers join insurance networks, and thereby help us all reduce the treatment gap and get kids the care they need much sooner.

AACAP: What is the concierge program and how does it operate?

Dr. Lustig: The Concierge Service’s intent is to ensure a quick and seamless process and help ensure it ends in a satisfying contract. It provides one point of contact on our recruitment team to essentially walk the child and adolescent psychiatrist or psychiatric nurse practitioner through the multiple-step contracting process. The specified recruiter will contact the provider within five business days to identify him- or herself as the point of contact during the contracting process and will follow up on a weekly basis to provide process updates and to answer any additional questions. Additionally, one of our own child and adolescent psychiatrist medical directors is available to talk with CAPs at any time during or after the credentialing process. We also provide a welcome letter with additional follow-up information so our collaboration with the clinicians who treat our members remains as easy and fulfilling as possible.

AACAP: Is Cigna investigating other means to assist with bringing more providers into the plan?

Dr. Lustig: Cigna is very interested in helping child and adolescent psychiatrists join our plan, and we are always interested in hearing if there are issues or opportunities that clinicians see as barriers. We welcome the opportunity to work with them to eliminate obstacles to their participation in our network.

AACAP: How can members contact this concierge program? And what should they expect?

Dr. Lustig: We have a terrific credentialing and provider relations team who would welcome any questions from interested clinicians. The fastest point of contact for the Concierge Service is Kristen Kirks at Kristen.Kirks@Cigna.com or 903.337.4821. And I’m always happy to talk with child and adolescent psychiatrists and nurse practitioners as well. My contact information is Stuart.Lustig@cigna.com, or 818 551-2757. Anyone calling us inquiring about our Concierge Service can expect a prompt reply and a description of the credentialing process.

Recovery in Rwanda continued from page 18

“Many of our most profound advances grew out of experiencing trauma.... trauma is now our most urgent public health issue, and we have the knowledge necessary to respond effectively. The choice is ours to act on what we know.”

Rwanda is putting these words into action. I hope its citizens will be able to continue on their path to recovery and that the rest of the world will take notice and follow their lead.

Dr. Ledbetter is a general and child and adolescent psychiatrist who enjoys traveling with her work as a provider through Locumtenens.com. She may be reached at marcialeeledbetter@gmail.com.
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**Honor Your Mentor**

in the March/April issue of **AACAP News**

In the March/April issue of **AACAP News**, you have the opportunity to honor your mentor(s). Whether you’re a medical student, resident, active researcher, practitioner, or retired, someone made a significant impact on your career.

We’re asking all of you to take the time to honor your mentor and tell others why they were important to you, and how they influenced your life.

In 100 words or fewer, tell us about your mentor. E-mail submissions to communications@aacap.org by February 10, 2016.

Please include your name, affiliation (if appropriate), the name of your mentor(s), and a short testimonial or anecdote.
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Thank you Fred, for once again donating your time and expertise in helping bring the Annual Meeting to life! Thanks for giving all attendees their 15 minutes of fame – and for capturing the essence of what AACAP is all about. You are our champion!
62ND ANNUAL MEETING RECAP

Photo Credit: Fred Seligman, MD
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Youth with Autism Spectrum Disorder: Challenges and Opportunities for the Transition to Adulthood

Current trends in autism research include a strong focus on early detection in an effort to facilitate intervention from the youngest age and maximize the possibility for positive outcomes. However, individuals with autism spectrum disorder (ASD) will spend most of their lives as adults, and there is a significant need for a better understanding of how they may be best supported. This need is even more relevant in an era of improved outcomes, as youth with ASD may choose to enter into careers and attend college—resulting in both challenges and opportunities.

In this symposium, Fred Volkmar, MD, from the Child Study Center at Yale University, began by highlighting the limited nature of current literature focusing on adults with ASD. He emphasized that despite an explosion in autism research, much of the current literature addresses younger individuals, and only a small fraction focuses on intervention. Thus, although it is a “good problem” that more youth with ASD are attending college, the challenge remains as how best to support these individuals given limited resources and evidence base.

Extending this theme, Gerrit van Schalkwyk, MBChB, a fellow in the Child Study Center at Yale University, spoke specifically about the challenges youth with ASD are likely to face on a college campus. The discussion included those aspects that are typically part of the developmental experience of being a college student, as well as specific comorbid psychiatric conditions like anxiety and depression. Dr. van Schalkwyk used two case examples from his own practice to highlight the need for a more flexible approach to psychotherapy, and to examine challenges specific to ASD that are important in treatment. Social skills training was emphasized as a potentially useful intervention for college students with ASD. Even those who may have had this treatment in the past can benefit from learning about the range of new social skills on the college campus. Students need to learn how to navigate novel social situations in order to maximize their chances of having positive peer relationships. Dr. van Schalkwyk pointed out the variable nature of ASD-specific services on college campuses. He noted that despite the significant changes in legal mandates for supporting these individuals relative to their time in high school, colleges were only required to provide “reasonable accommodations.”

In his presentation on psychopharmacology for adults with ASD, Christopher McDougle, MD, from the Lurie Center for Autism at Harvard University, summarized the existing literature, and provided several insights from his own clinical practice. The psychopharmacology literature for this age group is sparse. There are only a handful of studies looking at symptoms of aggression. There are no randomized studies examining agents commonly used to treat specific symptoms or comorbid conditions in adults with ASD. In reflecting on his substantial clinical experience, Dr. McDougle pointed out that he would not typically use stimulants as a first-line treatment for ADHD in individuals with ASD, and that he had experienced particularly good results with buspirone for anxiety—a medication that has fallen out of common use in recent time.

A particularly unique perspective was presented by Marc Woodbury-Smith, MD, from McMaster University, who discussed legal issues facing youth with ASD, particularly around their transition to adulthood. Dr. Woodbury-Smith began by highlighting recent portrayals in the media of individuals with ASD engaging in mass shootings or other violent crimes. Yet in reality these cases were not straightforward consequences of neurodevelopmental disorders, but rather tragic outcomes stemming from a variety of complex risk factors. By contrast, individuals with ASD were more likely to run into difficulty related to minor infractions, owing to factors like obsessively pursuing objects of interest, engaging in repetitive behaviors that become a public nuisance, and being excessively law abiding. One particularly interesting example was of an individual who carried hand-cuffs in order to be prepared to perform a citizen’s arrest. In his presentation, Dr. Woodbury-Smith highlighted how risks for legal involvement could be minimized through specific therapeutic interventions, and potential implications for assessment of competency to stand trial.

This Clinical Perspectives was well attended by over 200 attendees, highlighting the significant interest toward supporting youth with ASD around their transition to adulthood. Taken together, these four presentations provided a rich overview of many of the salient issues that occur during this developmental period. But perhaps more significantly, this program highlighted significant limitations in the current knowledge-base and resources and in what little is known about treatment. It underscored the need for broader participation in research relevant to the challenges experienced by young individuals with ASD.

Dr. Gerrit van Schalkwyk is a first year Child and Adolescent Psychiatry fellow at Yale University, and has a particular interest in clinical practice and research around adolescents and adults with ASD and associated symptoms and comorbidities. He may be reached at gerritvanschalkwyk@yale.edu.
Cannabis Explained: Answers to Questions You “Crave” to Ask

Dr. Atkinson presented possible explanations for the observed decreases in psychosocial achievement following cannabis. He analyzed marijuana’s effect on motivation through the mesolimbic dopaminergic system becoming less reactive following marijuana use, and motivational circuits being altered by targeted administration of Cannabinoid Type 1 (CB1) receptor agonists in the anterior cingulate.

Christopher J. Hammond, MD, presented on cannabis’ effects on cognition, intelligence, and mood. Acute effects include problems with processing speed, memory, attention, and executive function. Dr. Hammond listed findings of multiple impaired processes in cross-sectional studies of using youth, discussing limitations of particular study designs in determining causality and the duration of impairment. While most effects were found to be transient, resolving with 3 months abstinence, concern remains about enduring effects of adolescent use. The longitudinal Dunedin study showed a decrease in intelligence quotient (IQ) scores among those who used cannabis heavily in adolescence. This finding is concerning because IQ is generally quite stable throughout the life-span, and reductions in IQ were seen even in those who discontinued cannabis in adulthood. Use among adolescents is concerning both for the longer duration of residual impairments from heavy use and greater risk for enduring, long-term effects.

Dr. Hammond reviewed the risks for mood disorders and suicidal behaviors among adolescents using cannabis. Users have greater risk for major depression, which persists after controlling for covariates in about half of the studies. A large cohort study involving Australia and New Zealand found greater risks of depression, and the rate of suicide is greater in early-onset, daily users of cannabis.

Gregory Tau, MD, PhD, presented on changes in the legal status of cannabis, the development of “cannabis culture,” and potential effects of these changes. Medicalization has driven down perceived risk, and together with legalization, created a situation where at-risk teens can access diverted medical and legal marijuana. These changes have driven up potency and rates of use, leading to increased emergency department visits for cannabis-related issues: childhood ingestions, intoxication, cyclical vomiting, and to a greater proportion of drivers positive for THC.

To provide a culturally-informed approach to the adolescent cannabis user, Dr. Tau presented information on how these adolescents actually use. Common formulations for youth go beyond smoking cannabis plant, and increasingly involve the use of cannabis concentrates, such as “wax,” “shatter,” and butane hash oil. Dr. Tau described “dabbing,” using cannabis concentrates with the help of blowtorches, glassware, and titanium nails. Edible cannabis products also have growing acceptance. Dr. Tau concluded with information regarding the approach to a young person in cannabis culture, advocating for physicians to take a non-judgmental stance to improve the developmental trajectories of vulnerable youth.

Lydia Shrier, MD, MPH, presented on evidence-based methods for communicating with youths using cannabis. Dr. Shrier emphasized the need to normalize the discussion of substance use at the first visit. Confidentiality must be discussed in light of the need to inform parents if the adolescent is in danger. Dr. Shrier proposed a universal approach, treating all adolescents as if they are at-risk and in-need of an intervention. The SBIRT (Screening Brief Intervention Referral to Treatment) is an evidence-based way to approach the problem in youth. The use of validated screeners, e.g., CRAFFT, BSTAD (Brief Screener for Tobacco, Alcohol, and Other Drugs), S2BI (Screening to Brief Intervention), is important because the sensitivity of providers’ assessment of adolescent substance use disorders is low.

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Virtual Lives, Real Dilemmas: When Online Behaviors Impact Mental Health

Jennifer Zajac, DO, MS

As an early career psychiatrist, right out of fellowship, I was interested in learning about what our experienced colleagues have discovered regarding our young patients and their sometimes problematic behaviors related to Internet use and misuse. AACAP offered a Clinical Perspectives session dedicated to this topic sponsored by AACAP’s Adolescent Psychiatry and Media Committees.

Paul E. Weigle, MD, started the morning with “Internet Gaming Disorder: A Virtual Addiction,” in which he presented statistical and worldwide data regarding current characteristics of gaming habits as well as adverse effects in teens. Although not a formal diagnosis in DSM-5, Internet gaming disorder is listed under Section III of the Manual as a provisional disorder requiring further study. It is conceptualized similarly to the symptoms of a gambling addiction. Risk factors include male sex, social deficits, and impulsivity. Sequelae include poor academic functioning, worsening of social deprivation, and mood symptoms including anxiety and depression. At this time, the few studies on treatment interventions have not shown robust effective results.

Erin L. Belfort, MD, followed with “Texting, Tweeting, Posting, and Cutting? The Relationship Between Adolescent Social Media Use, Self-Harm, and Suicidal Behavior.” She spoke about the booming increase in teen’s access to the Internet, with 24% of teens reported to be on the Internet “constantly.” As an illustration, many teens will keep their smartphones turned on by their bed at night and, if woken up by an alert, will get up and engage in texting back and forth. Furthermore, 75% of adolescents are seeking health information online, including support for depression, from mostly inaccurate and unprofessional websites. Some teens are posting pictures and videos of themselves after self-harm and giving tips on how to conceal it from their families. Dr. Belfort suggests asking parents about their own social media use when discussing their teen’s use.

Elizabeth Englander, PhD, provided a new perspective with “Cyberbullying, Sexting, and Digital Munchausen.” In addition to concerns regarding online bullying and sexting, a new phenomenon called “digital Munchausen” is taking place in which a teen engages in “self-cyberbullying.” The teen creates a second online account or persona in addition to their primary account, and then uses the second account to bully the primary account in order to show others and “prove” that they are being bullied. This is an attempt to gain sympathy, although many youth report that self-cyberbullying ultimately does not make them feel better. Dr. Englander also talked about how many teens feel compelled to prevent rumors online, even if it is 2:00 a.m. and disruptive to their sleep. They feel that if they do not immediately deny a rumor then it will spiral out of control, leading to worse consequences at school the next day. Dr. Englander suggests that teens and parents discuss creating a family rule about electronics and maintain a protected dinette time, electronics-free.

Kristopher Kaliebe, MD, presented “What Are They Missing? When Electronic Media Displaces Sleep, Academics, and Exercise.” Poor sleep is a common problem with teens. With poor sleep, learning and memory becomes impaired, leading to declines in academic performance. Electronics in the bedroom and access to too many devices are contributing to sleep disruptions. Boys are reported to be heavier media users as compared with girls. Studies are also showing trends of obesity linked with young people spending inordinate amounts of time looking at electronic screens at the expense of regular exercise activities. Dr. Kaliebe shared a case study of a boy who spent 12 hours per day on electronic media. The boy’s mother described symptoms of minimal sleep, poor concentration, academic decline, lack of physical exercise, and mood swings. She thought he was showing signs of bipolar disorder or attention-deficit/hyperactivity disorder and wanted him to be medicated. The majority of his life was wrapped up in violent video games, television throughout the night, and activity on his smartphone. These preoccupations define the underlying problem and cannot be cured with a medication.

Jennifer Saul, MD, rounded out the morning with “Pro-Ana or Pro-Recovery? When Eating-Disordered Teens Interact Online.” Children as young as 12 years old are engaging in online community sites that are considered pro-eating disorder. Many are disguised as supportive sites, but ultimately provide tips and tricks for losing weight, starvation, calorie counting, excessive exercise, and hiding details from parents. More than 500 websites exist with hundreds of people visiting sites at any given time. Individuals with eating disorders describe themselves as being less social and lacking emotional support. In a survey, 96% reported having learned new weight loss strategies on a website with 69% reporting having used the strategy. Even those without an eating disorder reported negative consequences after viewing pro-eating disorder websites. They perceived themselves as weighing more, felt worse about their appearance, and had increased attempts at both exercise and reducing calorie intake.

The audience members were intrigued and compelled to share anecdotes of their own clinical experiences. Electronic and online media have evolved so rapidly that the average child and adolescent psychiatrist is having some difficulty keeping up with the online world. Guidance from continued on page 34
An International Perspective on Comorbidity in Tourette’s Disorder: Prevalence and Impact of Mood and Anxiety Disorders

The aim of the Symposium was to explore the role of mood and anxiety disorders in children and adolescents with Tourette’s Disorder (TD) in three different countries: Japan, Argentina, and the United States. TD is a developmental neuropsychiatric condition characterized by multiple motor and at least one vocal tic present for greater than one year with onset before age 18 years. Diagnostic criteria for TD are uniform throughout the world, and its prevalence has been reported in about 1% of the school age population in several countries and cultures. Although similarities in clinical presentation have been described such as higher prevalence in males, early age of onset, and strong familiality—variation in associated features have been found between countries.

Attention-deficit/hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD) are the most common psychiatric comorbid conditions in TD, and their prevalence has been widely examined. Obsessive-compulsive behaviors have been reported in 37-66% of TD samples from Brazil, Argentina, Costa Rica, United Kingdom (UK), and the United States. Rates of ADHD range from 16-60% in two different Argentinean samples, 44% in a United States sample, 60% in a UK sample, 69% in a United Arab Emirates sample, and 63% in a Brazilian sample.

Depression and anxiety disorders have also been reported frequently in youth and adults with TD, but their role and impact have been less widely investigated to date. An older study reported that major depressive disorders (MDD) in TD youth predict a greater level of both tic and overall illness severity (Coffey et al. 2000). Although depression in TD has been described by many others, it has often been associated with either ADHD or OCD. In contrast, a more recent study reported that MDD, independent of comorbidity with ADHD, tic severity, or other comorbidity, was significantly more likely to occur in older adolescents with TD as compared to community controls (Gorman et al. 2010). And most recently, a study from the Tourette Syndrome Association International Consortium for Genetics reported early onset anxiety disorders within one year of tic onset, and mood disorders in some patients beginning as early as age five years (Hirschtritt et al. 2015).

In order to explore the phenomenology of mood and anxiety disorders in TD from an international perspective, presenters from three different countries described current findings on the prevalence and impact of mood and anxiety symptomatology in children and adolescents with this disorder.

Yukino Kano, MD, PhD, from the Department of Child Neuropsychiatry, Graduate School of Medicine, University of Tokyo presented data from a sample of 44 pediatric patients with TD recruited in Japan. The objectives of the study were to: 1) Compare rates of anxiety and depression symptoms between a TD and a healthy controls sample and 2) Examine the role of demographic and clinical variables of TD subjects on developing depression and anxiety.

Subjects with TD were assessed with: State-Trait Anxiety Inventory for Children (STAI-C), Children Depression Inventory (CDI), Tic Symptom Self-Report (TSSR), Leyton Obsessional Inventory-Child Version (LOI-CV), and ADHD-Rating Scale (ADHD-RS). Sensory phenomena, distress caused by tics, and satisfaction with tic control were assessed by original questionnaires (SP scale, distress scale, and satisfaction scale).

In contrast to their expectations, severity of anxiety and depression symptoms was not found to be higher in subjects with TD than in healthy controls. Symptoms of anxiety and depression showed high correlations with motor tic severity, obsessive compulsive symptoms, sensory phenomena, and distress caused by tics. In multiple regression analysis, anxiety symptoms, sensory phenomena, and vocal tics were statistically associated with distress caused by tics.

Maria Beatriz Moyano, MD, from the Interdisciplinary Center for Tourette’s OCD and Related Disorders (Centro Interdisciplinario de Tourette, TOC, TDAH y Trastornos Asociados; CITA), presented data from a clinical sample of 115 Argentinian children and adolescents, ages 5-17 years. The aims of the study were to: 1) Describe rates of comorbid disorders in an Argentinian sample of children and adolescents with TD; 2) Examine associations between tic severity and ADHD, OCD, anxiety, and depression; and 3) Determine the relationship between objective and subjective measures of tics severity and global functioning. Subjects were assessed with: Kiddie-SADS-Present and Lifetime Version (KSADS-PL), Yale Global Tic Severity Scale (YGTSS), Child Behavior Check List-Parent version (CBCL), Screen for Child Anxiety Related Disorders (SCARED), Multidimensional Anxiety Scale for Children (MASC), Children’s Depression Inventory (CDI) and Global Assessment of Functioning (GAF).

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Cannabis Explained continued from page 31

Dr. Shrier presented brief evidence-based interventions to address adolescent substance use and reviewed the principles of motivational interviewing, including the collaborative nature of the conversation, open-ended questions, affirmations, reflections, summaries, and the need to avoid the “righting reflex,” whereby clinicians attempt to correct the adolescent. Finally, a NIDA-SAMHSA blending initiative was introduced, in which motivational interviewing research is disseminated to clinicians in an interactive, skill-building format, available at: www.tinyurl.com/Adolescent-MI.

Comorbidity in Tourette’s Disorder continued from page 33

In their sample, high rates of psychiatric comorbidities were found: 38.7% subjects with OCD, 55% with ADHD, 66.7% with anxiety disorders, and 30% with mood disorders. Depressive and anxiety symptoms, particularly when measured dimensionally by the MASC, were correlated with tic severity. A statically significant correlation was found between tic severity and measures of global functioning, especially when taking into account subjective measures of impairment.

Barbara Coffey, MD, MS, chief of the Tics and Tourette’s Clinical and Research Program at the Icahn School of Medicine at Mount Sinai, presented data from 72 patients with TD, ages 6-17 years, including 22 (31%) with comorbid DSM IV-TR anxiety disorders; and 37 healthy controls, ages 11-19 years. The aim of the study was to examine the relationship between tic severity and quantitative measures of anxiety in youth with TD. Anxiety was assessed using Multidimensional Anxiety Scale for Children (MASC) and tic symptoms and severity by the Yale Global Tic Severity Scale (YGTTSS). Extremes of score distribution were defined as high- or low-anxiety subgroups.

TD subjects exhibited higher anxiety severity than controls, even when subjects with comorbid anxiety disorders were excluded. Dimensionally, total severity tic scores were positively correlated with anxiety scores. Categorically, the high-anxiety TD subgroup, compared to the low-anxiety subgroup, did not differ on number of comorbid DSM anxiety disorders, but exhibited greater tic severity.

Discussion

These data suggest that anxiety and depressive symptoms are highly prevalent in youth with TD and may be associated with greater tic severity. For this reason, presenters emphasized the need to explore systematically anxiety and depressive symptoms in the evaluation of children and adolescents with persisting tic disorder. For the Argentinian and American samples, the findings also suggested that anxiety symptoms should be assessed using dimensional/self-report scales, as they may be more clinically relevant predictors of tic severity than categorical measures.

Presenters also highlighted the importance of evaluation of patients’ beliefs about their tics, as tic-related cognitions may be better correlated with anxiety symptoms than tic severity itself. This finding suggests a promising perspective on psychological therapies, and also stresses the importance of examining individual and cultural factors as part of the evaluation. Future plans to compare larger samples will be helpful in disentangling fundamental neurobiological characteristics of affective illness and cultural factors in youth with TD.

References


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colleagues regarding the assessment and treatment of these challenging cases is helpful. I was glad to have attended this Clinical Perspectives session and I have already started implementing media history-taking during evaluations in my outpatient clinic.

Dr. Zajac graduated from child and adolescent psychiatry fellowship in 2015 from the Institute of Living at Hartford Hospital. She is currently working at a community outpatient clinic, Child and Family Agency of Southeastern Connecticut, in New London Connecticut. She may be contacted at jenniferzajac@gmail.com.

Dr. Garcia-Delgar is a child and adolescent psychiatrist working at a hospital clinic in Barcelona. She is the recipient of a grant from the Alicia Koplowitz Foundation to do a research fellowship under Dr. Coffey’s supervision at the Tics and Tourette’s Clinical and Research Program at Mount Sinai, New York.

Dr. Coffey is professor in the Department of Psychiatry and chief of the Tics and Tourette’s Clinical and Research Program at the Icahn School of Medicine at Mount Sinai, New York. A unique focus of Dr. Coffey’s work has been comorbid anxiety and mood disorders in Tourette’s Disorder. She may be reached at barbara.coffey@mssm.edu.
Unaccompanied Latino Youth: Who is Taking Care of Them?

Hundreds of thousands of Central American children have fled violence, poverty, and mistreatment in their home countries over the past decade. In 2014, almost 70,000 children and adolescents (Customs and Borders Protection 2015) made the long and dangerous journey across rivers and mountains, with limited food, rest, and support. Up to 95% of these youth are coming from the Northern Triangle countries of El Salvador, Guatemala, and Honduras (Domínguez Villegas & Rietig 2015). The Northern Triangle Crisis is an under-recognized human rights tragedy that is tearing apart the region and causing mass emigration. The poverty, trauma, and limited resources born of this crisis deprive children of their childhood. What is worse, once these kids complete the arduous journey to the United States, their future is uncertain, and many of them are deported back to unsafe conditions.

Barbara Robles-Ramamurthy, MD, chaired the session and presented on the statistics and circumstances of these young refugee migrants. She noted that in 2015, there has been a significant decrease in the number of unaccompanied minors coming from Latin America (Customs and Borders Protection 2015). Many are concerned about the reasons for this decrease. The available data suggest that the primary reason is the Mexican government’s new aggressive anti-immigration enforcement strategy. Under pressure from the United States government, Mexico has increased border surveillance and internal checkpoints, leading to lengthier and more difficult journeys for these kids. Of greater concern is Mexico’s high deportation rate, which is up to 80%. A high percentage of deportees suffer violence once they are back in their home countries, which calls into question the adequacy of Mexico’s humanitarian screening process. It is imperative that the U.S. public becomes aware of the severity of the ongoing crisis that is being masked by a misleading decrease in the number of youth reaching the United States.

Up to 85% of apprehended, unaccompanied youth report a history of traumatic experiences, either in their home countries or during the immigration process. A 2012 report found that up to one-quarter of apprehended unaccompanied youth meet criteria for a psychiatric diagnosis and many are receiving psychotropic medications (United States Conference of Catholic Bishops 2012). This becomes a larger concern as these youth are either deported back to their home countries with no psychiatric treatment or are integrated into U.S. communities with scarce quality mental health services that are culturally sensitive and linguistically capable. In the United States, these youth have substantial difficulties accessing mental health services. Language is but one barrier. The children’s undocumented legal status leads to uninsurability, which in turn leads to little funding for comprehensive, culturally sensitive services. Additionally, evidence-based therapies have not been sufficiently tested in Latino populations, and practitioners need training and guidance on how to best serve this population.

Lisa Fortuna, MD, MPH, medical director of the Child and Adolescent Psychiatry Division at Boston Medical Center (BMC) and an affiliate with the Boston Center for Refugee Health and Human Rights at BMC, reviewed her research and clinical work with unaccompanied minors. Dr. Fortuna presented the results of a five-year study assessing a culturally-adapted Mindfulness-Based Cognitive Therapy for posttraumatic stress disorder (PTSD) for immigrant Latino and unaccompanied minors. The therapy model incorporated the following strategies: skills for coping with multiple, chronic and ongoing stressors; cognitive restructuring, including themes of spirituality and loss; and the promotion of social support and healing regarding relationships. Participants in the study improved in depression and PTSD symptoms, and had reductions in co-occurring substance use.

Dr. Fortuna also noted that close to 15% of immigrant minors are younger than five years of age. These children also suffer the effects of the trauma and separations endured prior to, during, and after migration. Boston Medical Center’s Child Witness to Violence Project offers therapies such as Child-Parent Psychotherapy (CPP), an intervention for children from birth through age five with behavior, attachment, and/or mental health problems, including PTSD: who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence). The primary goal of CPP is to support and strengthen the relationship between a child and caregiver as a vehicle for restoring the child’s sense of safety, attachment, and appropriate affect, and for improving the child’s cognitive, behavioral, and social functioning. Dr. Fortuna’s colleague, Carmen Rosa Noroña, clinical coordinator for The Child Witness to Violence Project, has worked with the immigrant Latino population through therapy approaches, including CPP. She

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integrates culture and an understanding of the impact of the immigration experience into her therapeutic approaches.

When providing services for unaccompanied Latino immigrants, it must be recognized that many of them are being reunited with family members. The reunification process can be very difficult, especially when family members have been separated for years. Changing roles, differing acculturation states, and variations in language mastery can present huge hurdles for families. Family members are often undocumented, which can prove very difficult for service coverage when accessing the health care system. There likely exists a multi-generational history of trauma, so obtaining mental health services for one person (who may be documented and insured), may not be sufficient when an undocumented and uninsured family member is in need of services as well.

Dr. Fortuna recommended that child mental health providers, including child and adolescent psychiatrists, will need to “think out of the box” in identifying how we can best offer evidence-based, culturally appropriate, and comprehensive care to our most vulnerable communities. Global payment strategies, medical home and integrated behavioral health in primary care, and services in schools and community organizations offer an opportunity to better reach all children with mental health needs, including immigrant youth.

Cathi Tillman, LSW, is the founder and executive director of La Puerta Abierta (LPA), a non-profit organization that promotes access to quality mental health care through training, education, and service to the immigrant Latino population in the Philadelphia, Pennsylvania region. LPA has key partnerships with immigrant-serving organizations in other regions of the United States. Tillman presented on La Puerta Abierta’s 5-year-old, community-based, immigrant-serving counseling program, which has filled a critical gap in services for unaccompanied minors through capacity-building, cross-system training and direct service. Tillman noted that although the “push” factors for children leaving their home countries vary, it is well documented that the majority have experienced protracted loss, intense community and/or family violence, and overwhelming fear and worry. The lack of reliable, consistent relationships during this critical developmental period in addition to numerous stressors before, during, and after the migration process put them at even higher risk for emotional and behavioral challenges. There is a chronic divide between identified mental health needs and available resources in most U.S. communities. Additionally, there is a disconnect between many mental health professionals who, despite having an interest in serving this population, experience a misalignment between urgency, concern, clinical training/supervision, and funding resources that could provide a culturally and clinically sound standard of care. Tillman concluded that community-based, partnership-centered program models that incorporate evidence-based practices, ongoing supervision and learning, with flexible approaches to care, are realistic and effective options in working with the complicated and growing population of unaccompanied minor children entering U.S. provider systems.

Ms. Tillman also noted a significant increase in referrals of families seeking support during the reunification process with their “newcomer” children or youth. Presenting concerns relate to the significant impact of protracted separations and difficulties adjusting to the complex family system changes during these separations. The combination of historical and personal trauma frequently presented in therapy by adult family members with the more recent traumas experienced by their newly arrived children requires a reevaluation of current treatment approaches and methodologies. Consideration of the transnational context and experiences that are brought into the therapy process is a critical step in this process. Tillman discussed LPA’s use of creative modalities, such as visual arts and story-telling, work to establish safe paths to healing for youth and families, many of whom are engaging in a therapeutic process for the first time.

References


Dr. Robles-Ramamurthy is a fellow at the Children’s Hospital of Philadelphia. She may be reached at barbararobles@gmail.com.

Dr. Fortuna is the medical director of the Child and Adolescent Division at Boston Medical Center. She is also a collaborator with the Boston Center for Refugee Health and Human Rights. She may be reached at lisa.fortuna@gmail.com.

Ms. Tillman is the founder and executive director of “La Puerta Abierta,” a non-profit organization that promotes access to quality mental health care through training, education and service to the immigrant Latino population in Philadelphia, Pennsylvania. She may be reached at icfanwell@gmail.com.
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Annual Meeting Musings

Samantha Phillips, Membership & Communications Coordinator

I joined the AACAP team in September, so a large portion of my work since I started revolved around the Annual Meeting. I had never before worked a conference nor even attended one of this size. While I worked on drafting emails and brainstorming promotional materials, I tried to wrap my head around what the Annual Meeting experience would be like. I received plenty of advice and input from coworkers as well as a handful of members, and the overall consensus, repeated by almost everyone I talked to, was wear comfortable shoes and get ready to learn a lot.

I took the comfortable shoes suggestion and added a cowboy hat to the mix as well—while in San Antonio, I figured. As for learning, I do undoubtedly feel like I now have a better understanding of AACAP and its members.

At Registration, the members that I interacted with seemed truly excited to be at the Annual Meeting and to be among others dedicated to children’s health. They were patient and happy to get to know a new staff member while I processed their requests, putting my training to work. Furthermore, I was pleasantly surprised by members’ readiness to laugh and have a good time—whether it was in response to Sheriff Nicole in the black and white dues video, the world map at the International Reception, themed Polaroid pictures taken by the Consumer Issues Committee, or dancing to Pink Freud at the Welcome Reception.

This willingness to have fun in the AACAP community was equally matched by the members’ work ethic. When it came down to business, members were ready to roll. I was impressed by the welcoming feeling extended at the committee meetings and the open dialogue that resulted. By simply observing the meetings I attended, I now certainly know more about military families, disaster and trauma issues, media, and school violence than I did when I walked in. I appreciated the friendliness that was personally shown towards me as well as the equal respect that was given to everyone in the room, whether it was an official member of the committee, a new participant, a committee chair of many years, or a medical student only beginning to get involved in the field. My takeaway was that AACAP is a genuine community that revolves around a meaningful, common cause with a great mentality of work hard, play hard.

With this greater understanding of the organization comes a new pride to be a part of it. So, thank you to all of the members who made my first Annual Meeting experience wonderful. I look forward to working with you as we move into 2016 and to sharing another productive, yet fun Annual Meeting experience with you in New York!

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James and Maureen Hackett

Can you share what one moment or event inspired you to focus your philanthropy on mental health?

Maureen: In 1998, our family went through a life-changing event; our 16-year-old daughter was sexually assaulted by a stranger while at boarding school, and that nightmarish experience turned all of our lives upside down. We knew it would be a long journey to bring her back to the young woman we had always known: bright-eyed, strong, and sure of herself. The legal and court process took almost 18 months. We had to make sure we had all the proper doctors treat her and have someone with her at all times so she would not self-harm, faint, or have a serious panic attack. It was a trying time for us, but we got through it by the grace of God and our deep faith.

It was at that point where we said, “We’ve worked terribly hard to get through all of this, but we would be remiss to not acknowledge that a major part of our success is due to our ability to access the resources we needed.” Neither Jim nor I grew up in families of means, and we knew what it was like to battle mental illness without any assistance. While Jim and I were blessed with the resources so critical to our family’s ability to overcome our daughter’s trauma, we were well aware that not everyone would be similarly situated to handle such difficult life experiences. We knew we needed to do something about the inequity of access to mental health care, and we have been working ever since to confront it head-on.

What was your first approach to dealing with the challenges of mental illness, and how has your approach changed over the years?

Maureen: Like a lot of people, my first reactions were fear and confusion; then, I turned to self-pity, I convinced myself that I was alone and nobody understood my experience. Luckily, I knew self-pity wasn’t going to make anything better in a world where mental illness was not specific to me. I knew that if I focused my energy out, I could help those who did not know how to help themselves. I made it a priority to educate myself. Why are we spending billions of dollars on cancer (which I think is phenomenal) but are not spending similar funds on the brain? Why aren’t we talking about mental health in the context of the brain as opposed to that of behavior? Mental illness is not some character flaw or poor choice deserving of punishment. If you have bad behavior, you sit in the corner. If you have a brain disease, let’s figure out how to treat it and prevent you from having to “sit in the corner” of life.

What solutions have been the most successful so far, and what are you excited about for the future?

Maureen: New diagnostic and clinical discoveries have been made that will allow our children to avoid suffering the same pain and prejudice as generations before them. There have also been innumerable research studies that have provided tons of data that can be used to map out solutions – but we have got to move now. We have to use that information, develop solutions, and implement them to better humanity. And we have to focus on integrative health care to make sure those solutions have the biggest impact possible. If we do not look at integrative primary care, how are we ever going to prevent anxiety or stress from leading to a stroke or a heart attack? I think integrative care is the only way to go. You go to see your doctor to tell him what hurts, but that is such a reactionary approach. He or she should be proactive; they need to ask, “How are you doing?” OB/GYNs need to ask expectant mothers, “How are you? Are you sleeping well? How’s your relationship with your husband, extended family, and community? Are you stressed at work?” We do not do that now, but it should be protocol.

You talk about servant leadership. Would you share a little more about what this means to you, and more importantly, how do we inspire others to apply this principle to children’s mental health?

Maureen: It’s tough to inspire servant leadership unless people are open to accepting that the reason we were all put on this Earth was to take care of our fellow man. This is not leadership that seeks recognition for how much money you have made or the size of the house you have built. It is servant leadership, which is service to others for the simple purpose of taking care of the person next to you, regardless of personal gain. Perhaps a lot of people do not know the value they have to offer outside of their wallets. Time and talent are just as important (in many cases, even more important than funding) to the progress and sustainability of mankind. Teach, spend time with those in need, offer
your talents as a board member or advisor, volunteer. That is servant leadership – focusing outside of yourself to elevate mankind.

What did it mean to you to attend the AACAP award reception in San Antonio?

Maureen: It was an opportunity for us to say, “Thank you for what you do, understand that what you do is God’s work, and please know that we support you.” We are greatly humbled by honors like that, but we are not motivated to serve by the potential for awards. We are just happy to be considered a small part of the solution and owe so much of that success to others. For me, the reception was a great opportunity to be authentic about why we are involved and to say thank you. The field of mental health can be frustrating at times because of the many hurdles that exist with respect to policy, funding, accessibility, etc. We were glad to be able to plead with those in the room making a real difference not to jump ship in fear that they are navigating the waters alone. We wanted to assure everyone that we are right there with them, and we will not give up.

In your acceptance of AACAP’s Humanitarian Award, you made the following statement: “We waged a war on a long-standing human rights violation.” You said this with such passion and purpose. Can you tell us more about where this comes from and how we get others to join in this “war”?

Maureen: I think the war we can wage for this cause would be similar to many others...civil rights, women’s rights, etc. It requires an all-out assault on the status quo. We have to bring public awareness to the science of the brain and explain the myriad ways the health of the brain affects families, corporations, industries, economies, generations, etc. Then, we have to demand equal access to mental health care for all mankind from our leaders. The reason I say it is a war is because we cannot back down from the fight under any circumstances. We can not let opposition stop us from obtaining this basic human right for everyone.

What motivates you as philanthropists?

Maureen: Philanthropy is more important and personal to us than the financial contributions we have made; it was taught to us as young children, long before we had the finances to make gifts. Philanthropy is care of humankind and is something central to our family and our faith. We want to bring about changes that could help the entire world. I do not know if it is going to happen in our lifetime, but we think being change-makers is important regardless.

How do you think the stigma of mental illness has changed in the past 10 years, do you feel we can end it, and if so, how?

Maureen: First and foremost, I think we are finally starting to talk about it for what it is – brain health. By discussing it in the proper context of a physiological issue, we have removed a lot of the negative connotations. So the challenge for us is to inform the conversation about mental health through greater education and public awareness. Social media can play an enormous role in this. A couple of years ago, we capitalized on this opportunity and worked with a production and documentary film company to create the Mental Health Channel, a 24/7 internet channel people can view in the privacy of their own homes, on mobile devices, etc. It has been very successful, and I think we can extrapolate from that by creating apps, getting educational programming on public television, and more.

I think schools can also play a huge role in providing greater awareness. Schools are central to so many people’s lives; there are few similarly influential mechanisms through which to deliver critical information to both students and their families. Other centers of influence to focus on are faith communities; individuals and families alike rely on and respect their religious and cultural leaders.

You know that NIH and NIMH funding is rapidly declining. How do we get the private sector (individuals and corporations) to invest in children’s mental health research?

Maureen: We ask them, “What are you funding and why? Have you done a full audit of critical needs? Have you spoken to the beneficiaries of services? How do they feel about the organization(s) you’re supporting? What role do you want to play in the overall ecosystem of mental health and is your current approach helping you achieve that?” Recently, I have attended a number of conferences where fabulous research and technical data was provided by SAMHSA and NAMI. So, if the research has been gathered and analyzed, how many donors and recipient organizations are using it? If donors are going to get involved, then they need to know there’s an actual plan informed by research that will yield solutions (not further issues). It is imperative that the private sector listen to what people are screaming that they need in order to respond with appropriate solutions, or so much of the funding available to organizations will be wasted. Focusing on children, and particularly philanthropic efforts aimed at children’s mental health care, is a focus on the future of humankind. That’s something that should unite and direct all of us.

What do you envision for the future of children’s mental health research?

Maureen: I think we are going to have much more robust, technical information...more than we even have today. The research is not just cutting-edge; it is over the edge! We are approaching the point where we can talk about in-utero detachment and whether it will have a post-partum impact on a child. Early identification and prevention of serious mental illness, as well as greater understanding of how to treat these illnesses at a very young age, is the most exciting thing about the future of children’s mental health research to me. To know that our world is quickly shifting from reactionary treatment to prevention gives me great hope.

You ended your remarks saying, “We must live our commitment to mental wellness out loud...we must commit to make some noise...to make the loudest noise we can, to provide mental health care to all, and especially children.” This is a fearless shift in thinking. How do we help to achieve this?
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Maureen: We talk about it. We put information into people’s hands, whether that be through social media, classrooms, discussions, whatever. We give people all the information they need to understand the human brain and how it serves as the hub for everything else in our bodies. If we don’t make some noise about allowing research to be done and practicing the innovative techniques that need to be perfected, it will go away. I fear that this is not a popular political issue, and I wonder whether it ever will be.

In the meantime, we each have a part to play as members of the private sector.

When my daughter Kelly hears someone say, “I really think depression is a behavioral problem,” she responds with, “That sounds like a really unfortunate personal problem. I’d love to share some information with you and talk to you about my own journey.” She refuses to give strength to the uninformed words of opposition, and I think that’s something more people should do.

Get the facts – that’s our first role. Then put the facts out there for others and remain strong, knowing that we can not expect to change the mind of every opponent we meet. We have to collaborate with others who feel the way that we do. That’s the noise we need to make…educated noise. We should never have a quiet day.

We have a terrific opportunity right now, more than what we had 25-30 years ago when I started down this path, because we have so much more information. We just need to share what we know, execute our plan, and believe in our ability to be change-makers. People in each sector (business, medical, any kind) need to stand up and say, “You’re right, let’s do this together!”

FOR YOUR INFORMATION

AACAP Catchers in the Rye Humanitarian Award

Deadline March 13, 2016

Nominations are now being accepted for the American Academy of Child and Adolescent Psychiatry (AACAP)’s Catchers in the Rye Humanitarian Award. This award honors a non-AACAP-member who has made significant contributions to the field of children’s mental health. Contributions may include but are not limited to philanthropy, research, entrepreneurship, advocacy, increasing awareness, acts of bravery and kindness.

The AACAP Catcher’s in the Rye Humanitarian Award recipient will be recognized for their impact on children’s mental health at the 2016 AACAP 63rd Annual Meeting in New York, NY, from October 24th–October 29th. Recipients are required to attend the awards ceremony at the Annual Meeting.

All nominations must be submitted to the AACAP Development Office via email at development@aacap.org. Nominations must be in a Word document or PDF. Please write “AACAP 2016 Humanitarian Award Nomination” in the subject line of the email.

Humanitarian Award Nominees:

- Only AACAP members may submit nominations
- Only non-AACAP-members are eligible to receive the award
- Nominees from the New York area are encouraged

Please submit the following information with the nomination:

- Name and contact information, including email, phone number, and mailing address, of nominator
- Name and contact information, including email, phone number, and mailing address, of the nominee
- 2-3 paragraph biography or C.V. of the nominee
- 250-500 word explanation of why the nominee deserves the award
- If available, supporting information that would be helpful to inform the selection committee, such as a website, book, magazine or journal profile

If you have questions about the award or the process, please contact Alan Mark Ezagui, MHCA, AACAP Deputy Director of Development at 202.966.7300 ext. 130 or aezagui@aacap.org.
Members of the 100% Club: Are you in?

The following child and adolescent psychiatry Residency Program Directors recruited all of their residents to be members of AACAP. AACAP acknowledges and warmly thanks the following Residency Program Directors for their support. All of their residents have become AACAP members as of October 1, 2015.

Allegheny Health Network Medical Education Consortium (AGH)
Vered B. Cohen, MD

Ann & Robert H. Lurie Children’s Hospital of Chicago / McGaw Medical Center of Northwestern University
Julie Sadhu, MD

Baylor College of Medicine
Laurel L. Williams, DO

Brown University
Jeffrey I. Hunt, MD

Cambridge Health Alliance
Sandra DeJong, MD

Carilion Clinic-Virginia Tech Carilion School of Medicine
Felicity Adams, MD

Children’s Hospital of Philadelphia
Tami Benton, MD

Children’s National Medical Center/George Washington University
Lisa Cullins, MD

Creighton University/University of Nebraska
Jamie Snyder, MD

Emory University
Jennifer Holton, MD

Hofstra North Shore-LIJ School of Medicine
Richard Pleak, MD

Icahn School of Medicine at Mount Sinai
A. Reese Abright, MD

Icahn School of Medicine at Mount Sinai (Elmhurst)
Barbara Coffey, MD

Icahn School of Medicine at Mount Sinai/ St. Luke’s-Roosevelt Hospital Center
Georgia Gaveras, MD

Institute of Living/Hartford Hospital
Robert Sahl, MD

Johns Hopkins University
Roma Vasa, MD

Los Angeles County-Harbor-UCLA Medical Center
Kathleen McKenna, MD

Louisiana State University
Martin Drell, MD

Louisiana State University – Shreveport
Rita Horton, MD

Maine Medical Center
Sandra L. Fritsch, MD

Maricopa Medical Center
Shayne Tomisato, MD

Mayo Clinic College of Medicine (Rochester)
Sandra Rackley, MD

Medical College of Georgia
Sandi Saxson, MD

Medical College of Wisconsin Affiliated Program
Kathleen Koth, DO

Michigan State University
Madhvi Richards, MD

Montefiore Medical Center/Albert Einstein College of Medicine
Louise Ruberman, MD

New York Presbyterian Hospital (Columbia)
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John E. Bragg, Jr., MD

Ponce Health Sciences University
Nuria Sabate, MD

Rush University Medical Center
Adrienne Adams, MD, MS

Rutgers Robert Wood Johnson Medical School
Wun Jung Kim, MD, MPH

Southern Illinois University
Ayame Takahashi, MD

Stanford University
Shashank V. Joshi, MD

SUNY Health Science Center at Brooklyn
Cathryn Galanter, MD

SUNY Upstate Medical University
James Demer, MD

Texas A&M College of Medicine- Scott and White Program
Kyle E. Morrow, MD

Thomas Jefferson University
James Luebbert, MD

Tripler Army Medical Center
Stephanie Leong, MD

Tulane University
Myo Myint, MD

University of Alabama Medical Center
Lee I. Ascherman, MD, MPH

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Molly Gathright, MD, BS

University at Buffalo
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Peter T. Daniolos, MD

University of Louisville
Christopher Peters, MD

University of Maryland
Sarah M. Edwards, DO

University of Massachusetts
Mary Ahn, MD

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Laine M. Young-Walker, MD

University of Nevada School of Medicine (Las Vegas)
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University of Texas Health Science Center at San Antonio
Brigitte Bailey, MD

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Douglas Gray, MD

University of Vermont / Fletcher Allen Health Care
David Rettew, MD

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Ray C. Hsiao, MD

Vanderbilt University Medical Center
Edwin Williamson, MD

Vidant Medical Center / East Carolina University
Nadyah J. John, MD

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H/SLCH Consortium
Anne Glowinski, MD, MPE

West Virginia University
Bharati Desai, MD

Wright State University School of Medicine
Christina G. Weston, MD

Yale University School of Medicine Child Study Center
Dorothy Stubbe, MD
Welcome

New AACAP Members

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Idil Aldemir, MD, Istanbul, Turkey
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Souzana Alkhouri, Oklahoma City, OK
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Safiah Amara, Mason, OH
Ana Anguita Oliveras, MD, Coamo, PR
Azeesab Babajide, MD, Los Angeles, CA
Ganji Brehani, Dearthorn, MI
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Adem Gunes, MD, Istanbul, Turkey
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Paola Tran, MD, Stanford, CA
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Rong Xiao, MD, Salt Lake City, UT
Yingcheng Xu, Philadelphia, PA
Esther Yang, MD, Orange, CA
Kristen Yost, MD, Camp Hill, PA
Haining Yu, MD, MPH, San Francisco, CA
Nitya Zaveri, MD, Minneapolis, MN
Haining Yu, MD, MPH, San Francisco, CA
Kamleh Shaban, MD, Louisvile, KY
Nisha Shah, MD, Pittsburgh, PA
Harry Siegel, Houston, TX
Distinguished Member Awards

Deadline: May 2, 2016

The availability of all awards is contingent upon the receipt of adequate funding.

AACAP is pleased to offer the following award opportunities to our many outstanding members. For details about all awards, eligibility requirements, and for access to applications and nomination information, please visit the AACAP Awards Webpage at: www.aacap.org/AACAP/Awards/Distinguished_Member_Awards/Home.aspx

All Distinguished Member and Service Awards are conferred through a nomination process. Distinguished Member and Service Award recipients will be recognized at the Distinguished Members Awards Luncheon and will give an Honors Presentation regarding their work at the AACAP Annual Meeting, October 24-29, 2016 in New York, NY.

AACAP Cancro Academic Leadership Award

The AACAP Cancro Academic Leadership Award recognizes a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of Pediatrics or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry. This award offers a $1,000 honorarium to the award recipient. The award recipient will receive a plaque and will be recognized at the 63rd AACAP Annual Meeting in New York, NY.

AACAP George Tarjan Award for Contributions in Developmental Disabilities

This award recognizes a child and adolescent psychiatrist and Academy member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with mental retardation and developmental disabilities. These contributions must have national and/or international stature and clearly demonstrate lasting effects. The contributions may be in areas of teaching, research, program development, direct clinical service, advocacy or administrative commitment. A cash prize of up to $1,000 will be awarded. Nomination letters must be accompanied by a CV for the individual nominated. The award winner will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during the AACAP 2016 Annual Meeting in New York, NY.

AACAP Irving Philips Award for Prevention

This award recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents. These contributions must have national and/or international stature and clearly demonstrate lasting effects. The contributions may be in areas of teaching, research, program development, direct clinical service, advocacy or administrative commitment. The award pays $2,500 to the winner and a $2,000 donation to a prevention program or center of the awardee’s choice. Nomination letters must be accompanied by a CV for the individual nominated. The award winner will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during the AACAP 2016 Annual Meeting in New York, NY.

Jeanne Spurlock Lecture and Award on Diversity and Culture

Jeanne Spurlock, MD, was a giant in child and adolescent psychiatry and in advocacy for children, adolescents, and their families from all cultures. Dr. Spurlock co-chaired the AACAP’s Work Group on Diversity and Culture from 1995 through 1999. Her commitment to recruit members from diverse cultures into child and adolescent psychiatry is legendary. The AACAP created this lecture and award in her honor to recognize her work and encourage others to follow her example. The Lecture/Award is funded by the Jeanne Spurlock Minority Fellowship Fund.

Simon Wile Leadership in Consultation Award, supported by the Child Psychiatry Service at Massachusetts General Hospital

This award acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry. The $1,000 award is named after Simon Wile, MD, a renowned pediatrician and a life-long supporter of child and adolescent psychiatry. Nomination letters must be accompanied by a CV for the individual nominated. The awardee will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during the AACAP 2016 Annual Meeting in New York, NY.

AACAP Rieger Psychodynamic Psychotherapy Award

This award recognizes the best published or unpublished paper, written by an AACAP member, that uses a psychodynamic framework and presents:
1) clinical material demonstrating the inner life of an infant, child or adolescent or 2) research material that promotes psychodynamic principles in order to illustrate the paper’s idea or hypothesis. The paper should include consideration of a DSM diagnosis and a focused literature review that includes current psychiatric literature. The material for this paper may be drawn from clinical practice or from clinical research. The recipient will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during the AACAP 2016 Annual Meeting in New York, NY.

AACAP Rieger Service Program Award for Excellence

This award recognizes innovative programs that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community. This award of $4,500 is shared among the awardee and his or her service program. Nomination letters must be accompanied by a CV and any support materials for the individual or organization nominated. The recipient will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during the AACAP 2016 Annual Meeting in New York, NY.

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This award recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness. A cash prize of $4,500 will be awarded. Nomination letters must be accompanied by a CV for the individual nominated and program information. The awardee will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during the AACAP 2016 Annual Meeting in New York, NY.

For more information on how to apply for AACAP’s Distinguished Member awards please visit the AACAP Awards page online at www.aacap.org/AACAP/Awards/Distinguished_Member_Awards/Home.aspx.
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