Inside...

President’s Message: Guest Article, AAP’S Child Poverty Agenda, • Bernard P. Dreyer, MD, FAAP…..270
Ethical and Legal Issues in Child Psychiatry: Consent, Privacy and Refusal of Treatment .....................275
Tracking Applications and Monitoring Online – Good Parenting or a Violation of Trust? .....................281
AACAP Advocacy and Collaboration Grants .........................................................................................285
2016 Distinguished Fellows! .................................................................................................................298
Save the dates!

January 20-21, 2017

Gabrielle A. Carlson, MD, and Manpreet Kaur Singh, MD, MS, Co-Chairs
The Westin St. Francis San Francisco - San Francisco, CA

Register by December 7 at www.aacap.org/psychopharm/2017.
Questions? E-mail meetings@aacap.org.
Columns
Neera Ghaziuddin, MD, Section Editor • neerag@med.umich.edu

President’s Message Introduction • Gregory K. Fritz, MD ................................................................. 269
Guest Column: AAP’s Child Poverty Agenda • Bernard P. Dreyer, MD, FAAP ...................................... 270
Guest Column: Integrated Care in Disadvantaged Communities: A Model Program • Andrea E. Spender, MD ........................................................................................................... 271
Editor’s Note • Uma Rao, MD .................................................................................................................. 273
Clinical Care Reports and Vignettes: A Note From the Column Coordinator • Jeffrey Hunt, MD ............... 274
Diversity and Culture: Ethical and Legal Issues in Child Psychiatry: Consent, Privacy and Refusal of Treatment • Balkozar Adam, MD ........................................................................................................... 275
Psychotherapy: Sergio Delgado, MD, Receives AACAP Norbert and Charlott Rieger Psychodynamic Psychotherapy Award • Rachel Ritvo, MD ........................................................................................................... 277
International Relations: A Child Psychiatrist in Malawi • George Stewart, MD ........................................ 279

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

Media Committee: Tracking Applications and Monitoring Online – Good Parenting or a Violation of Trust? • Paul Weigle, MD ........................................................................................................................................ 281
Telepsychiatry Committee: Keys to a Successful Telemental Health Practice • Felissa Goldstein, MD .................................................................................................................................................. 283
AACAP Advocacy and Collaboration Grants • Debra Koss, MD ................................................................ 285

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

2016 AACAP Virginia Q. Anthony Outstanding Woman Leader Award: Gabrielle A. Carlson, MD .................................................................................................................................................. 286
Call for Nominations .................................................................................................................................... 287
Media Page • Erik Loraas, MD ................................................................................................................................ 288
Poetry • Dance • Alvin Rosenfield, MD ........................................................................................................... 290

Opinions
Harmony Raylen Abejuela, MD, Section Editor • harmonyraylen@hotmail.com

On the Value of Our Medical Training • Edmund C. Levin, MD ..................................................................... 292

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

Call for Papers. ............................................................................................................................................... 294
Call for Exhibitors! ........................................................................................................................................... 295

For Your Information

Membership Corner ....................................................................................................................................... 297
In Memoriam .................................................................................................................................................. 297
2016 September/October Cover Correction ................................................................................................. 297
Congratulations to the 2016 New Distinguished Fellows! ........................................................................... 298
Welcome New AACAP Members ................................................................................................................ 299
Thank You for Supporting AACAP! ............................................................................................................ 302
Get in the News! ............................................................................................................................................. 304
AACAP Award Opportunities ....................................................................................................................... 306
Policy Statements ............................................................................................................................................ 308
Classifieds ..................................................................................................................................................... 310

Cover Photo: The simplicity of childhood. Girl and doll, Isla del Sol, Bolivia: Sandra Nelson, MD
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

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

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

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

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

AACAP EXECUTIVE COMMITTEE
Gregory K. Fritz, MD, President
Karen D. Wagner, MD, PhD, President-elect
Tami D. Benton, MD, Secretary
Yiu Kee Warren Ng, MD, Treasurer
Mark S. Borer, MD, Chair, Assembly of Regional Organizations of Child and Adolescent Psychiatry

COUNCIL
Gabrielle A. Carlson, MD
Cathryn Galanter, MD
Shashank V. Joshi, MD
Debra E. Koss, MD
Douglas A. Kramer, MD
Kaye L. McGinty, MD
Melvin D. Oatis, MD
Kayla Pope, MD
Marian A. Swope, MD
Jose Vito, MD

JERRY M. WIENER RESIDENT MEMBER Aaron J. Roberto, MD
JOHN E. SCHOWALTER RESIDENT MEMBER Jennifer Creedon, MD
ROBERT L. STUBBLEFIELD RESIDENT FELLOW George “Bud” Vana IV, MD
EXECUTIVE DIRECTOR Heidi Büttner Fordi, CAE
JOURNAL EDITOR Andrés Martin, MD, MPH
PROGRAM COMMITTEE CHAIR Boris Birmaher, MD

COLUMN COORDINATORS
Ayesha Mian, MD, mian@bcm.tmc.edu
Jeffrey Hunt, MD, jhunt@lifespan.org
Sala S.N. Webb, MD, webbpsychiatric@gmail.com
Arden Dingle, MD, adingle@emory.edu
Rachel Ritvo, MD, rrzmd@comcast.net
Charles Joy, MD, crijoy1@gmail.com
Kim Masters, MD, kmater105@gmail.com
Mark Chenven, MD, mchenven@vistahill.org

AACAP News is an official membership publication of the American Academy of Child and Adolescent Psychiatry, published six times annually. This publication is protected by copyright and can be reproduced with the permission of the American Academy of Child and Adolescent Psychiatry. Publication of articles and advertising does not in any way constitute endorsement or approval by the American Academy of Child and Adolescent Psychiatry.

© 2016 The American Academy of Child and Adolescent Psychiatry, all rights reserved
PRESIDENT’S MESSAGE

Introduction

Recently, I was fortunate enough to speak with Bernard P. Dreyer, MD, President, American Academy of Pediatrics (AAP). We discussed a myriad of topics, including my Presidential Initiative on Integrated Care, how our organizations can best work together in the future, and a topic close to his heart – child poverty.

Because I was inspired by our conversation, I reached out to Dr. Dryer directly to ask if he would be interested in writing for AACAP News. I was impressed with how quickly and resoundingly Dr. Dreyer expressed a positive response to my request. On a personal note, I am grateful for the effort and time Dr. Dreyer took in writing an article for AACAP News.

I am excited to share with you the following article from Bernard P. Dreyer, MD, on the AAP’s Child Poverty Agenda.

GUEST COLUMN

AAP’s Child Poverty Agenda

As a medical student, I volunteered on the child psychiatric floor of Bellevue Hospital, which cared for the underserved. I had seen statistics on poverty, but I had never really seen poverty and what it could do to a child’s physical and mental health.

These were great kids, and the more I got to know them, the more I realized that most of these children and teens did not have innate mental health problems, they had social and family problems and were simply reacting to the chaos in their lives. It was my first exposure to the social determinants of health. And it taught me that health is so much more than medical care.

Poverty is the most pervasive non-communicable disease children suffer from today. Some 16 million U.S. children live in poverty. That is one in five! And it is not just kids in urban and rural areas who are afflicted. Since the 2008 Great Recession, the largest and fastest increase in poverty has been in the suburbs.

The impact this has on child health is enormous. Research shows that children who are born into poverty – and persistently live in poor conditions – are at great risk for a host of adverse health and developmental outcomes throughout their lives. Child poverty is linked to higher rates of asthma, obesity, infant mortality and greater risk of injuries. What is more, the effects of persistent poverty can lead to toxic stress, which alters a child’s genomic function and brain development. This contributes to lower educational attainment and higher rates of teen pregnancy, incarceration and substance abuse – all of which lead to intergenerational poverty, as it is so hard to break the cycle.

Because poverty is at the root of so many health and behavioral problems – and can undermine all we do in the health care system – the American Academy of Pediatrics (AAP) has made alleviating poverty and its effects on child health a strategic priority. This past spring, the AAP published a report and policy in our Pediatrics journal to help pediatricians care for children in poverty. Our recommendations include screening for poverty risk factors and connecting families who are struggling to resources for housing, food, health insurance and other services they need to get their children on a path to better health.

We have also created tools to help pediatricians put these recommendations into practice including sample screening questions, a model for making community referrals and communication materials and guides to help them sensitively broach the subject with families. (You may access these resources at www.aap.org/poverty.)

Using these tools and resources, our members are helping families turn things around and are having a meaningful impact on the health of the children and communities they serve.

continued on page 270
In addition, the AAP is calling on lawmakers to invest in policies and programs that we know help lift children out of poverty and improve their health. These include:

- **Early childhood education programs**, which have been shown to mitigate toxic stress by providing children with a nurturing, positive environment, cognitive stimulation and nutritious meals. Investing in these programs yields returns on investment as high as 14 percent per year, while it also lowers rates of remedial education and juvenile crime.

- **Nutrition programs** like the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) improves birth outcomes, school readiness and cognitive performance. Nearly half of all Supplemental Nutrition Assistance Program (SNAP) recipients are children, and children who receive SNAP have better health and educational outcomes than low-income children who do not.

- **Affordable, high-quality child care** increases disposable income and eases stress for parents and has many developmental benefits for children. The federal government and states provide child care subsidies to low-income families with children under age 13. But because of limited funding, fewer than 1 in 5 eligible children benefit from child care subsidies.

- **Higher family incomes** are linked with better child health and education. The Earned Income Tax Credit (EITC) and Child Tax Credit have reduced family poverty by more than 40 percent and lifted 5 million children out of poverty. Children whose parents receive these tax credits have been found to have better health and a better chance of finishing high school and going to college. Helping a child reach these milestones puts us one step closer to overcoming the hardships associated with childhood poverty. Because so many poor children have parents with minimum-wage jobs, increasing the minimum wage is also critical.

By joining forces and speaking with one voice, we can help make addressing child poverty a national priority. Realistic, effective solutions are well within our reach. But it will take all of us who care for children to put those solutions in place, so that we can conquer the disease of poverty and give all children a healthy start.

---

Benard P. Dreyer, MD, FAAP, President, American Academy of Pediatrics (AAP), Professor of Pediatrics, Director of Developmental-Behavioral Pediatrics, NYU School of Medicine, Director of Pediatrics, Bellevue Hospital Center.

---

**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, or 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 less, tell us who served as your mentor. E-mail submissions to communications@aacap.org by January 10th, 2017.

Please include your name, affiliation (if appropriate), the name of your mentor(s), and a short testimonial or anecdote.
GUEST COLUMN

Integrated Care in Disadvantaged Communities – A Model Program

Andrea E. Spencer, MD

O

Of the many important reasons to improve the integration of mental health care within primary care pediatrics, reducing disparities in care for the most vulnerable children is perhaps the most pressing and poignant. Economically disadvantaged and minority children suffer from a high burden of chronic disease including mental illness (Price et al, Biomed Res Int. 2013) (Liao et al., MMWR Surveill Summ. 2011). High rates of environmental and social stressors including community violence, economic hardship, and single parenthood contribute to higher levels of risk for these children. But disadvantaged and minority families utilize subspecialty psychiatric care at lower rates than other families (Coker et al., Acad Ped, 2009)(McAlpine and Mechanic, Health Serv. Res. 2000) (Flores and Tomany-Korman, Pediatrics, 2009), for a variety of reasons including economic and cultural. Lack of timely access to care for these children increases their risk for morbidities that already disproportionately affect underserved communities and which bear a significant cost to society and individuals, including school failure, teenage childbearing, unstable employment, marital instability, violence, psychiatric and physical comorbidities, and substance use disorders (Mental Illness Exacts Heavy Toll, Beginning in Youth: NIMH; June 6 2005, Wang et al., 2004).

In disadvantaged communities, embedded child psychiatry fee-for-service consultation could be particularly useful for overcoming certain barriers to care.

On-site consultation could reduce certain logistical and financial barriers including locating a specialist, obtaining and paying for transportation, and missing extra time from work associated with extra travel. This model could also help to overcome resistance to care associated with stigma against mental illness by locating the psychiatrist in a familiar and more trustworthy environment. It could not only improve patients’ access but also reduce no-show rates for psychiatrists evaluating publicly insured patients. Increasing the direct contact between psychiatrists and pediatricians could also improve pediatricians’ knowledge and comfort level with psychiatric problems. Finally, such an arrangement presents a greater opportunity for effective co-management of mental health conditions by psychiatrists and primary care clinicians.

At MGH Chelsea HealthCare Center, we have piloted an embedded consultation model. “MGH Chelsea” is a community-based health center associated with Massachusetts General Hospital located in the city of Chelsea, Massachusetts. Most of the city’s residents are Latino and speak Spanish at home, and many suffer from severe poverty and low educational attainment (Census Viewer 2014). The Adolescent and Pediatric Practice at MGH Chelsea is the largest pediatric practice in Chelsea and the largest affiliated with MGH for Children, where 13 pediatricians conduct about 12,000 well child visits each year in a Family-Centered Medical Home model. The practice uses the Pediatric Symptom Checklist (PSC) to screen school-age children for behavioral health symptoms. MGH Chelsea also has a Behavioral Health Unit staffed with psychologists, social workers, and psychiatrists, some of whom see children. Children referred to Behavioral Health establish care with a therapist prior to accessing an evaluation with a child psychiatrist.

In 2013, MGH Chelsea developed a new program that allows pediatricians to refer patients directly for a consultation on diagnosis and treatment recommendations with a bilingual child psychiatrist available within their department. The goal of this program was to reduce barriers associated with accessing psychiatric evaluation including long wait times, high drop-out rates, stigma, and poor provider communication. Referred patients are scheduled to see the consulting psychiatrist for an initial evaluation, followed by a plan for short-term (3-6 month) stabilization if needed. All patients are seen within the Pediatrics Unit. The long-term goal is transition of care back to primary care pediatrician, and more infrequently co-management between the psychiatry consultant and primary care provider. A pilot study examining preliminary feasibility of this model is underway, and preliminary data has started to teach us some important lessons that could be applied to future embedded psychiatry models.

Over 200 patients were referred during the first year and a half of our program. Although “no shows” are a common problem in this urban clinic serving mostly publicly insured patients, most referred patients came in for an evaluation. Patients were actually more likely to show for a psychiatric evaluation in the embedded model compared to usual care.

Pediatricians referred with questions about diagnosis, medication management, and recommendations for follow up care. The most common reason for referral was ADHD, followed by mood symptoms, anxiety symptoms, behavior problems, and developmental concerns. Many patients had multiple diagnoses as well as a previous history of mental health treatment.

Our preliminary analysis suggests that younger patients and those with higher total and externalizing symptom scores on their last PSC were more likely

continued on page 272
Integrated Care in Disadvantaged Communities continued from page 271
to show for an initial appointment. Furthermore, the higher the PSC score, the more visits a patient was likely to have, suggesting that more impaired patients were seen more times. The number of visits per patient varied considerably, but most patients were seen for 3 or less visits.

This model is a departure from usual care for psychiatrists and other mental health professionals, pediatricians, and patients. Adapting to increased access to child psychiatry and understanding a primary care consultation model involves a “learning curve” for the whole system. While in our experience, pediatricians (and pediatric subspecialists) adapt fairly quickly to the idea of consultation and short term care because they appreciate any access to child psychiatry, they may need coaching on the appropriateness of referrals and on the need for closer follow up in primary care for patients “transitioned back.” This education can be provided in real time by the child psychiatrist. Pediatric support staff (e.g. nurses, medical assistants, and front desk staff), who may take phone calls from patients between visits, will also need education on the model. Support staff benefit from clear documentation of a care plan as well as protocols for referrals and prescription refills, especially for controlled medication that may be prescribed at one time by psychiatrist and at another by the primary care provider.

Community providers and school staff accustomed to old models of care often will initially assume that a patient is establishing a long term treatment relationship. Some families may enter the evaluation with this in mind as well. Thus, the consultation psychiatrist must set clear expectations about the model of care, and the system must have a mechanism for community referrals for families who need more support. On the other hand, in our experience, having an embedded child psychiatrist in the office that is well-connected with patients’ primary care physicians can provide a significant source of comfort for both families and providers. Knowing that the same specialist is available for questions or an additional appointment if needed can ease the transition back to primary care. The opportunity for “co-management” with primary care can also provide an option for more complicated patients.

Finally, child psychiatrists are also often not trained in this type of outpatient primary care consultation-liaison (CL) model. Clearly explaining and documenting one’s role, planning for the transition back to primary care, maintaining availability for new patients, and developing principles and protocols for co-management are key components to the model’s success that differ from older outpatient practice designs. Furthermore, the role requires a different skill set and treatment framework compared to inpatient CL, in which child psychiatrists field a different distribution of referral questions and treatment goals (Carter et al., J Pediatr Psychol, 2003). Despite the adjustment, this role can be extremely rewarding, particularly for a psychiatrist working in an underserved community. The reduction in “no shows,” opportunity for team-based care and continuing education with pediatrics colleagues, and range of clinical questions and disease severity could increase satisfaction for both psychiatrist and pediatrician. Alongside such promise, certainly many more questions remain to be answered, and as these models become more common it is imperative to share knowledge of both the bumps and the benefits along the way.

References


Mental Illness Exacts Heavy Toll, Beginning in Youth: NIMH; June 6 2005


Dr. Spencer is currently an attending child psychiatrist and Associate Director of Integrated Pediatric Behavioral Health at Boston Medical Center. She is Assistant Professor of Psychiatry at the Boston University School of Medicine, where she studies outcomes of care integration and developing interventions to improve ADHD care in the primary care pediatric setting.
Greetings from the AACAP News Editorial team. I hope you had an enjoyable and productive trip to the Annual Meeting in New York. For those of you who did not attend the meeting, this issue will provide you with some highlights from the meeting.

It has been my privilege and honor to serve as the News’ editor. Time has flown by! I am very grateful to the editorial team and the membership for all the accomplishments in the past four years. I would like to take this opportunity to update you on recent additions/changes.

- We strive for diversity in authorship as well as content. Authors have included academicians and private practitioners, clinicians and researchers, and all stages along the career path from residents and early career psychiatrists to seasoned veterans in the field to retirees. This could not have been accomplished without significant contributions from individual authors, coordinators, and section editors. We continue making strides to publish on a wider diversity of topics important to our members and encouraging more members from varied backgrounds to submit articles.

- Consistent with the Presidential Initiative on integrated care of Gregory K. Fritz, MD, AACAP President, we have published several interesting topics in this area.

- We initiated a new section, Psychopharmacology Corner. Gabrielle Carlson, MD, the Section Editor, and her recruits have made diligent efforts to distil the research in this critical field to provide practical information to clinicians.

- We initiated a new column, Systems of Care, and Mark Chenven, MD, is the coordinator for this column.

- While the Clinical Case Vignettes have been popular over many decades, they have been primarily limited to psychodynamic themes. We have expanded this column to include a variety of interesting case reports, including complex diagnostic issues, pathophysiology and a range of treatments. Jeffrey Hunt, MD, is the new coordinator for this column.

- In order to provide opportunities to the wider membership to serve on the editorial team, we make changes to the editorial team at regular intervals. Neera Ghaziuddin, MD, has joined the team in January 2016 to serve as the editor for the Columns Section. She has replaced Jean Dunham, MD. Harmony Raylen Ahejuela, MD, who was the resident editor until last year has transitioned from the Media Section to Opinions Section. Erik Loraas, MD, is the new Resident Editor. Christopher Varley, MD, who served as the Opinions Section editor departed from the team last summer. Dale Peebles, MD, is the new Youth Culture column coordinator.

As a final note, I would like to emphasize that the AACAP News belongs to you. I seek your input to help shape it. Please share any new ideas you have with me, as well as criticisms, by contacting the management team (Rob Grant, the Managing Editor, or me), or any of the section editors or coordinators. Also, I welcome your individual contributions as authors. If you are doing work you think might of interest to other members, please submit it. While we cannot promise that every submission will be published or that every criticism will be translated into an actionable item, we are committed to working with you to accomplish these goals. I can be reached at urao@utk.edu. Rob Grant can be reached at rgrant@aacap.org. Contact information for the other editorial board members and coordinators is provided in the masthead of the AACAP News. In addition to the hard copy, members can read the AACAP News online at the following link: http://www.aacap.org/AACAP/Member_Resources/News/HomeNews.aspx.
I am pleased to introduce an expansion of the AACAP News Clinical Vignettes Column to include clinical case reports that will come from the entire range of practice in child and adolescent psychiatry. AACAP News has for decades focused on psychotherapy cases and vignettes, and these submissions will continue to be represented. This expanded column recognizes that our field has evolved into a myriad of fascinating areas of clinical work, and the column will highlight this diversity. One needs just to read the registration magazine of the AACAP 2016 Annual Meeting to see the great breadth and depth of our field. This column will hopefully see representative cases submitted from child and adolescent psychiatrists in all of these areas.

The column also addresses the fact that it is increasingly difficult to find venues to publish case reports. Most high impact journals either do not accept case reports or have limited them to brief letters to the editor. Although case reports are considered in the lower tier of the evidence-based hierarchy, they clearly have a role in depicting clinical work in a naturalistic setting with greater description of the context, which is often missing in randomized controlled treatment trials that have excluded many patients with comorbid conditions.

I am currently program director of the Child and Adolescent Psychiatry Fellowship and Triple Board Program at Brown University and the Director of Inpatient and Intensive Services at Bradley Hospital in Rhode Island. I am also part of a research team at Brown University focusing on longitudinal follow-up of bipolar disorder and the treatment of adolescent mood disorders. I have been frequently struck by the diversity and complexity of cases that we all struggle to manage. Nearly every clinician and trainee that I have had contact with has had unique and interesting patients that could be the focus for a case report.

This column is open to all AACAP members, including clinicians in academic and non-academic settings, as well as all child and adolescent psychiatry trainees. Members should submit case reports of 600-1200 words with five or less references to me for review prior to publication. There will be up to three case reports published each year. The cases should be well described and should have an educational value for members to consider. The cases could highlight an aspect of clinical practice that needs to be modified or be in an area where further research is needed. Examples of possible themes include:

- Unusual side effects or adverse interactions involving medications
- Unusual presentations of a common disorder
- Descriptions of a rare disorder
- Unexpected outcomes in treatment
- Notable challenges in working with families, schools and other systems
- Cultural issues in treatment
- Cases involving interface with pediatrics
- Early positive findings related to emerging treatments

The content should generally follow usual standards for case reports. Recently, a consensus concerning the optimal structure of clinical case reports was published that can be useful in helping members craft their submissions (Gagnier et al. 2013).

The case reports for this column should include:

- Title
- Introduction of clinical issue or issues being presented in the case
- Patient description with clinical findings, timeline of disorder and diagnostic assessment
- Therapeutic interventions, follow-up and outcomes
- Discussion and recommendations for further exploration

Members should be sure to de-identify the patient material and obtain informed consent when needed. If the case report contains one or more of the 18 Personal Health Information (PHI) data elements, then written patient authorization would be required by HIPAA regulations. Additionally, institutions will vary regarding the need for IRB approval when two or more cases are reviewed. Authors should discuss with their local IRB prior to submitting for publication.

Case reports should be sent to me at Jeffrey_hunt@brown.edu. I will provide edits and suggestions as needed. We are hopeful that many Child and Adolescent Psychiatry, Triple Board, Integrated, and Post Pediatric Portal training programs will take advantage of this column, as successful publication will easily satisfy some of the ACGME scholarly activity requirements.

Reference


www.jmedicalcasereports.com/content/7/1/223

Dr. Hunt is professor and program director at Alpert Medical School of Brown University. He is co-chair of the AACAP Training and Education Committee. He may be reached at Jeffrey_hunt@brown.edu.
DIVERSITY AND CULTURE

Ethical and Legal Issues in Child Psychiatry: Consent, Privacy and Refusal of Treatment

Balkozar Adam, MD

Unlike adults who can make decisions about what treatment they want – or don’t want – children face a myriad of complex issues that factor into their ability to control their medical care. This primarily stems from children’s inability to make informed decision. Their brains are not fully developed; their life experiences are incomplete; and their ability to understand long-term consequences is limited. However, that does not mean that adults should be the sole decision-makers when it comes to minors’ treatment. In fact, the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics strongly encourage adults — be they clinicians or guardians — to involve the minor in decisions related to his or her care.

The question that arises then becomes just how much autonomy a minor should have when it comes to treatment. Given the vastly different rate at which minors develop emotionally and intellectually, age cannot be the sole determinant. Research shows that some 14-year-olds have the ability to understand their diagnosis and voice sound opinions related to their treatment, while others may still be years away. Until minors turn 18, parents generally have the decision-making capacity over treatment, though that’s not always the case. In emergency situations, or when dealing with a “mature minor” or emancipated minor, adolescents do not need parental consent to receive treatment (Maradiegue 2003).

State laws provide some clarity, though they vary from state to state. Most states empower parents to consent on their children’s behalf for medical treatment. A 2015 study that reviewed the various state laws related to mental health and substance abuse consent issues found that laws required parental consent more often when the minor was receiving mental health treatment (Kerwin et al. 2015). More than half the states required such consent in inpatient settings, but only 39-46% required parental consent in an outpatient setting. When it came to substance abuse treatment, minors were able to access treatment without parental consent more often than not — and frequently at a younger age than for mental health. States also typically grant exceptions from parental consent for contraception, sexually transmitted diseases, HIV treatment and pregnancy-related care.

The issue of consent becomes even trickier when the minor or guardian refuses treatment. In those cases, it is helpful to keep in mind these four principles from the AACAP’s Code of Ethics (AACAP 2014):

2. Nonmaleficence: Minimizing harmful effects.
3. Autonomy: Grant respect for the choices and wishes of the individual patient.

While each principle stands on its own, applying all of them to one case may be problematic, as they may compete with each other. It is important for clinicians to remember the larger picture and end goal when considering each case individually.

When parents refuse the recommended treatment, the clinician has to step in to seek the best possible care for the minor. Sometimes these refusals stem from religious objections. The United States Supreme Court has ruled that parents can cite religious beliefs when it comes to their children’s treatment, but that right is not absolute (Black 2006). The caveat remains that those beliefs cannot put the minor at grave risk. Childhood vaccination has been in the news lately, as some parents are practicing their legal right to refuse vaccines for their children, despite a significant health hazard to the children and the community at large. After a measles outbreak that started at Disneyland in California and spread to affect 150 people, the governor there signed a law last year that banned religious waivers as exemptions for vaccinations (Brown 2015). In a case in Oklahoma, parents cited religious beliefs when they stopped medical treatment for their severely ill daughter, but the court overruled and determined that the child was in danger of suffering further brain damage or even dying without treatment.

When it is the minor who refuses treatment that could save his or her life, the issue becomes more complicated. The clinician needs to determine if the refusal is based on the minor’s religious beliefs or the beliefs of his or her guardians. Equally important is determining how beneficial the treatment will be. Underlying these factors is the minor’s competency to understand the potential outcome of refusing care.

In addition to religious considerations, clinicians should be cognizant of racial, ethnic, and culture considerations of minority patients. Some cultures may not readily recognize mental health diagnoses, while others may initially cast off treatment because of the stigma surrounding mental illness. Minors and their parents alike may need an interpreter or a cultural consultant to help explain the extent of the illness and treatment options before either will consent. When resolving either the parents’ or minor’s

continued on page 276
decision to refuse care, clinicians who have exhausted respectful and cooperative means may have to seek assistance from child protection officials, the state or the court.

Muddying the waters even more are the issues of privacy and confidentiality. While all patients are entitled to privacy, not all are guaranteed confidentiality. In cases where a minor may present a threat to self or others, the clinician is obligated to alert guardians or authorities. In more common situations, guardians may demand information the minor disclosed to the clinician with the understanding that it will remain confidential. Keep in mind that some minors may not seek needed treatment if they believe their confidentiality will be compromised. That is why it is critical that the clinician explain at the get go the extent of confidentiality to both the minor and the guardian. Creating a clear confidentiality policy will help to avoid piecemeal decisions and inconsistencies.

In addition, because not all states adhere to the same laws when it comes to confidentiality of minor patients, clinicians must remain up to date on their state laws (Bruce et al. 2008).

References


Dr. Adam is a child and adolescent psychiatrist and clinical associate professor of psychiatry at the University of Missouri-Columbia. She may be reached at adamb@health.missouri.edu.
COLUMNS

PSYCHOTHERAPY

Sergio Delgado, MD, Receives AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award

Sergio V. Delgado, MD, professor at the University of Cincinnati School of Medicine, Cincinnati Children’s Hospital Medical Center, won the 2016 AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award for his paper “Two-Person Relational Psychotherapy: High School Age Adolescents.” The paper is a chapter in Contemporary Psychodynamic Psychotherapy for Children and Adolescents: Integrating Intersubjectivity and Neuroscience, written by Dr. Delgado in collaboration with colleagues at the University of Cincinnati: Jeffrey Strawn, MD, and Ernest Pedapati, MD.

In this paper, Dr. Delgado demonstrates through the case of Michelle, a 16-year-old, how traditional “one-person” psychodynamic theories and techniques (drive theory, ego psychology, object relations and self-psychology) compare with contemporary intersubjective theory and techniques. Over the past thirty years a confluence of thought in relational psychoanalysis and research in developmental psychoanalysis, such as the work of Emde and Stern, has led to a heightened awareness that the therapeutic action in psychoanalysis and psychotherapies is not solely, or even primarily, reliant on delving into the intrapsychic, subjective reality of the patient (one-person focus) but arises from the interspersic matrix of the patient’s and therapist’s experience of one another (intersubjective focus).

Michelle has difficulty coping with sad feelings stemming from the breakup of a two-year, long-distance relationship with a 17-year-old girl whom she had never met in person. Since the breakup, Michelle had spent much of her time in her room crying and requested that her mother “find someone I can talk to….it is not right to feel this bad.” Previously a good student, after the breakup she had begun to struggle at school. Dr. Delgado provides Michelle’s history of birth to a teenage mother who relinquished her to her grandparents at age three and then took her back at age thirteen when the mother’s life had settled down. Michelle’s father had ceased his intermittent contacts when she was ten. Although Dr. Delgado and Michelle agree that abandonment is one of her issues, his intersubjective approach does not dwell on discussing the past or expecting Michelle to understand her past.

A detailed description of the work that transpired is provided revealing the way in which the intersubjective experience in the here and now of the sessions guided the psychotherapist’s interventions during the process. The reader is given a running commentary of the therapist’s thoughts and feelings. He explains how he used this intersubjective awareness to guide his technique, noting that “much of what transpires that promotes changes and moves along the process occurs at an implicit nonverbal level and is strongly influenced by the patient’s and psychotherapist’s tone of voice, posture, and nonverbal expressions in the here-and-now moments.” Those who wonder what is actually said and done during a therapy session will find this case illuminating. What may be of particular interest to the novice therapist is Dr. Delgado’s description of how he discusses with the adolescent her mother’s phone conversation with him before the session. Equally compelling is his description of recognizing that, at a point when he had become tired and uncomfortable, he disengaged and changed the subject creating a disruption of the patient’s flow of feelings and concerns. He describes different theoretical approaches to this disruption but most importantly gives the reader a model of his use of a self-reflective approach to repair the breach.

The inspiration for Dr. Delgado’s paper and book came from his residents who responded to his supervision and teaching of psychodynamic theory and technique, particularly the intersubjective approach, by repeatedly urging, “Please write a book.” Dr. Delgado is eager to have early career child and adolescent psychiatrists understand that psychodynamic theory and practice have not stood still since Sigmund and Anna Freud did their work.

After medical training in Monterrey, Mexico, Dr. Delgado, encouraged by his mentor, Dr. Cesar Garza-Guerrero, went to the Menninger Clinic in 1981 for his psychiatric and child and adolescent psychiatry training. He studied adult and child psychoanalysis in the intellectually rich and eclectic Topeka Psychoanalytic Institute (TIP) where he became both a supervising and training analyst. He says of TIP, “an eclectic institute permitted

continued on page 278
me to have a balanced and in-depth understanding of the pluralistic traditional one-person models and the two-person relational models, which is not the case at all institutes.” While at Menninger, he had the opportunity to meet Sir John Bowlby, Dr. Daniel Stern, and Dr. Robert Emde. Dr. Emde invited him to co-author a case report, a project that he says, “solidified my thirst to learn two-person, relational psychology in depth and began my questioning of the ‘truths’ of the traditional one-person model.” Dr. Delgado took up an appointment at the Cincinnati Children’s Hospital in 2002. Today, he is director of outpatient services in the psychiatry department there. Having joined the Cincinnati Psychoanalytic Institute, he strives to introduce the two-person perspective on psychoanalytic work. In particular he has launched a Relational Advanced Psychotherapy Program.

Dr. Delgado feels strongly that faculty and leaders in child psychotherapy practice need to encourage early career child and adolescent psychiatrists to write about therapy.

He hopes Rieger winners, past and future, will make themselves available as mentors. He understands the fear and doubt early career psychiatrists may feel about clinical writing. He himself faced “thinking in Spanish and writing in Spanglish,” which for many years discouraged him from writing. This prize-winning paper demonstrates his mastery of writing in English. The difficulties he had learning to write in a second language inspired Dr. Delgado, while at Menninger, to work with a learning disability specialist in order to delve more deeply into cognitive and learning issues of his patients and to write about these issues. He is now sought out by educational specialists “to help parents understand that oppositional behaviors are likely due to difficulties in cognition and learning.”

Dr. Delgado’s paper was chosen from a field of six submissions in this fifteenth year of the Rieger Psychodynamic Psychotherapy Prize. Timothy Dugan, MD, who co-chaired the judging team with Helene Keable, MD, said of this paper, “Given that I am not a ‘theory guy,’ I often can’t see the relevance of theory papers to our clinical work. This paper of Sergio’s truly integrates a depiction of a recent theory and moment-to-moment clinical work with a patient. Hoorah for clear and pragmatic psychoanalytic talk!”

Dr. Ritvo is assistant clinical professor of Psychiatry and Behavioral Sciences at the George Washington University School of Medicine and Health Sciences; is on the faculty of the Baltimore-Washington Psychoanalytic Institute and Children’s National Medical Center; and has a private practice in Kensington, Maryland. She may be reached at rzritvomd@gmail.com.

### Rieger Psychodynamic Psychotherapy Recipients

<table>
<thead>
<tr>
<th>YEAR</th>
<th>RECIPIENT</th>
<th>PAPER TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Rex McGehee, MD</td>
<td>Child Psychoanalysis and Obsessive-Compulsive Disorder: The Treatment of a 10-Year-Old-Boy</td>
</tr>
<tr>
<td>2002</td>
<td>Vernon Rosario, MD, PhD</td>
<td>Psychodynamic Therapy with an Aphallic Child: Intersex Gender Identity and Early Sex Reassignment</td>
</tr>
<tr>
<td>2003</td>
<td>Candace Good, MD</td>
<td>Teaching Residents to Integrate Psychodynamic Play Therapy Into the Multimodal Treatment of Disruptive Behavior Disorders</td>
</tr>
<tr>
<td>2004</td>
<td>Barbara Milrod, MD</td>
<td>A Pilot Study of Psychodynamic Psychotherapy in 18 to 21 Year Old patients with Panic Disorder</td>
</tr>
<tr>
<td>2005</td>
<td>NO AWARD</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Theodore John Gaensbauer, MD</td>
<td>Traumatized Young Children: The Treatment Process</td>
</tr>
<tr>
<td>2007</td>
<td>Rachel Seidel, MD</td>
<td>Anna, Leaving for College: Interruption, Separation and Termination in the Psychoanalytic Treatment of an Adolescent Girl with Bulimia</td>
</tr>
<tr>
<td>2008</td>
<td>Helene Keable, MD</td>
<td>But Now I Have a Huge Memory</td>
</tr>
<tr>
<td>2009</td>
<td>Lenore C. Terr, MD</td>
<td>Using Context to Treat Traumatized Children</td>
</tr>
<tr>
<td>2010</td>
<td>Daniel S. Schechter, MD</td>
<td>When Parenting Becomes Unthinkable: Intervening With Traumatized Parents and Their Toddlers</td>
</tr>
<tr>
<td>2011</td>
<td>NO AWARD</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Ann Alaoglu, MD</td>
<td>Untangling Psyche and Soma: A Traumatized Adolescent with Lyme Disease</td>
</tr>
<tr>
<td>2013</td>
<td>John K. Burton, MD</td>
<td>Neutrality, Abstinence, and the Therapist’s Sexual Orientation: Complex Meanings for the Adolescent in Treatment</td>
</tr>
<tr>
<td>2014</td>
<td>Michael Shapiro, MD</td>
<td>Pseudohallucinations in an Adolescent: Considerations for Diagnosis and Treatment</td>
</tr>
<tr>
<td>2015</td>
<td>Daniel S. Schechter, MD</td>
<td>Traumatically Skewed Intersubjectivity</td>
</tr>
<tr>
<td>2016</td>
<td>Sergio Delgado, MD</td>
<td>Two-Person Relational Psychotherapy High School Age Adolescents</td>
</tr>
</tbody>
</table>
The title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.

I arrived in Lilongwe, the capital, on July 23, 2016, after spending a fascinating 10 days at Peace Corps headquarters in Washington. My group there worked hard, absorbing lectures all day about tropical diseases, safety, HIV/AIDS, and other topical issues. Once in Lilongwe, we had two additional weeks of orientation to the country, with daily Chichewa (language) lessons, skits on cultural sensitivity, and many practical matters. Then our counterparts, those in-country with whom we would be most closely aligned, met us and we all drove in buses to our sites. I am in Blantyre, the commercial center of the country, as is the title is accurate. I am the only child and adolescent psychiatrist in Malawi, a southeast African nation of 16.8 million people. There is only one other psychiatrist in the country, the director of Mental Health at the College of Medicine (COM) where I am teaching for a year. There is a lot of physical and sexual trauma, AIDS orphans, post-cerebral malaria brain damage, and extreme poverty here, as well as all the regular mental health issues. It feels overwhelming as I write it, but being here is so novel and interesting that I can only think about the Big Picture when I am brainstorming research ideas or system changes with others in the department of mental health.
A Child Psychiatrist in Malawi continued from page 279

months at a time to teach in the College of Medicine. The two I have met were well-informed and delightful.

Malawi has many beautiful areas, including Mt. Mulanje, one of the highest peaks in southern Africa. We took a guide and a porter and went up there for three days over a weekend. Lake Malawi is one-third the area of the country. It is the third largest lake in Africa and has the largest number of species (>600) of fish of any fresh-water lake in the world. There are game reserves, high plateaus, pottery and wood carving villages—so much to enjoy! The markets, where bargaining is the order of the day, are fabulous. In the United States, purchasing something is a straightforward, rather sterile transaction. Here, it is a social interaction; the sellers smile happily when you arrive at a price that you both like. It is said that the way to ruin a Malawian’s day is to pay the full price; the seller will then wonder all day that they could have charged more. Bargaining is addictive!

GHSP provides us with a house—we have a spacious three-bedroom, three-bathroom home with a large, fenced front and back yard at the end of a dead-end road. We are starting a vegetable garden and there are avocado and guava trees, two frangipani trees and an incredible weeping willow/bottle brush tree currently in bloom in front of the house. We are on a hill and look up at an amazing mountain, Mt. Sochi, from our front porch. There are servants’ quarters in the rear, but no one lives there. We are provided a guard and a gardener for free and have a housekeeper/laundress three times a week for $20 a month. It feels colonial but it provides people with jobs for which they are grateful. We also are given mountain bikes and helmets by the Peace Corps, which allow us to get around, if we are not on foot. I brought home a case of Carlsberg for a party on the back of my bike, pushing it awkwardly for over a mile. A slender woman passed me, gracefully carrying about 75 pounds of chickpeas in a container on her head. Made me feel feeble!

This week was the Silver Jubilee (year 25) of the College of Medicine with celebrations that included dancing, drumming, speeches, and research presentations every day; and a banquet and fireworks completed the occasion.

I would encourage any AACAP member, young or old (I just turned 76) who wants an adventure and a change of perspective to contact Peace Corps GHSP. It is a remarkably well thought out and well supported operation. Our training is fabulous, the students are wonderful, and the very large canvas is quite blank.

Dr. Stewart is a child and adolescent psychiatrist from Berkeley, California, who is currently spending a year teaching in Malawi. He may be reached at georgehstewart000@gmail.com.
Tracking Applications and Monitoring Online – Good Parenting or a Violation of Trust?

Everywhere you look, children and teens are online. Whether at home, social events, at family functions, or restaurants, and often even at school, young people typically seem preoccupied with cell phones, tablets, or computers. Parents are often nearby physically, but typically have little involvement or even knowledge of their children’s online behaviors and activities. A 2015 survey indicates that children average over 4.5 hours per day on-screen media for entertainment, and teens average 6.5 hours per day (Block 2014). Nearly half of that screen time is consumed on a mobile device. It is becoming more common for even elementary-school aged children to own a smartphone with relatively unrestricted, unlimited, and unmonitored Internet access.

In psychiatric practice, we often see the negative effects unrestricted computer activities have on children and adolescents. Although Internet Gaming Disorder is currently a condition requiring further study in the DSM, research confirms that excessive or addictive video gaming or Internet habits are frequently associated with new-onset or worsening insomnia, depression, anxiety, and academics (Gentile et al. 2011, 2014). Inappropriate Internet use, whether it involves online bullying, sexting, pornography, dating or ‘hook up’ sites using location services, excessively violent video gaming, or online involvement with peer groups that support drug use, cutting, or eating disordered behaviors, frequently causes or exacerbates mental health problems in our patients.

As child and adolescent psychiatrists, it is our duty to guide our patients and their families towards safe and healthy habits, including computer habits. However, there are few commonly accepted guidelines for doing so. The American Academy of Pediatrics has recommended that parents make a media plan including education, supervision, and restriction of total screen time to one or two hours per day, allowing no screens in a child’s bedroom.

Before a child gets access to the Internet, especially via a new computer, tablet, or smartphone, it is vital for parents to teach children guidelines for going online. The best way to do this is by example: parents must moderate their own online habit, ensuring it does not interfere with their responsibilities and relationships. Discussions should include teaching digital citizenship and establishing how and when the device is to be used (including mealtime curfew and a ban on devices in the bedroom at night), what websites the child is allowed to visit, what videos the child is allowed to watch, what the child can and cannot disclose to strangers, and how to post in a respectful and safe manner and what to do in response when others do not. Issues of cyberbullying and sexting must be discussed in a developmentally appropriate manner.

It is imperative for parents to understand that they have not only the right, but also the responsibility to supervise their child’s online activities. The developing brain is more susceptible to harmful influences, such as addictive behavior, so protecting children from unhealthy online experiences is vital. A prospective study demonstrates the powerful protective effects of parental media supervision on a child’s behavior, sleep, body mass index, and school performance (Rideout et al. 2015). Media supervision is particularly important for children and younger teens who have recently gained access to new online freedoms (such as acquiring a new smartphone) or whose online behavior has seriously violated rules or caused significant consequences. However, there is little agreement regarding how parents should supervise children’s media use, and reliance on traditional direct supervision can be particularly challenging. Children can easily thwart direct supervision by deleting instant messages or browser histories, and closing pages or applications at a parent’s approach. Supervision becomes exponentially more difficult when a child owns a smartphone and uses it outside of the home. Parents can set up restrictions on smartphones, tablets, and computers regarding how they will function. For his thirteenth birthday, I gave my son his first smartphone, but he can use it primarily to text, listen to music, and access a limited number of educational applications without access to a web browser, games, and the ability to download applications.

Tracking applications are relatively novel tools that allow parents (typically with a fee-based subscription) greater access to information about their child’s online activities and even their physical location. These applications continued on page 282
can also be useful for teens who have problematic involvement with drugs, sexting, or cyber-bullying, have made suicidal threats, or have been negatively influenced by online communities or peers. Children and teens typically do not appreciate any type of supervision, and often complain that the use of these tracking applications is essentially spying and constitute a lack of trust and violation of privacy.

The difference between supervising children and spying on them is whether or not the children are aware that their activities are being monitored. Therefore, parents should inform their children beforehand that they will be checking on the child’s online activity. Checking on their activity without informing children beforehand can more accurately be seen as a violation of trust and risks damaging the relationship. When a child protests regarding feeling untrusted, a parent can truthfully respond that they are not yet satisfied that the child is ready to behave appropriately in all situations, but the child has the opportunity to prove herself/himself over time. At times, teens have expressed relief that their parents are monitoring their devices, as it becomes a convenient way to save face to peers while allowing a teen to resist unwanted peer pressure to sext, glorify drugs, or engage in other unhealthy behaviors.

Naturally, supervision can become excessive. Parents must supervise when it is important to ensure healthy habits, not simply to satisfy their own curiosity. A teen ultimately needs to learn to handle issues on his or her own and accept the consequences. Ultimately, the best way to make children and teens safe is to teach them to take care of themselves. In addition, having a healthy amount of privacy in relationships is important for social development in adolescence. Therefore, as a child or teen demonstrates good digital citizenship and adherence to house rules and restrictions, supervision should be gradually lifted over a course of years. These can be reinstated in case of a significant violation or when new online freedoms are granted.

Parenting children and adolescents who are raised in an Internet-saturated world is in many ways more complicated but, as child and adolescent psychiatrists, we can help parents use the tools at their disposal to protect their children from unhealthy habits and dangerous exposures, while teaching them self-control and granting them sufficient freedom needed to become healthy adults.

References


Dr. Weigle is associate medical director and president of the medical staff at Natchaug Hospital, of Hartford Healthcare in Connecticut. He has served on the Media Committee since 2002. He may be reached at paul.weigle@hhchealth.org.
TELEPSYCHIATRY COMMITTEE

Keys to a Successful Telemental Health Practice

Felissa Goldstein, MD

Introduction

AM, a six-year-old male, goes with his mom to his school-based health clinic for an appointment with a telepsychiatrist. AM’s mother and his teachers have been concerned about his behavior and academic progress. Since there was not a psychiatrist in their community, AM’s parents choose to have him evaluated via teleconferencing. When they arrive at the clinic, the psychiatrist dials into the clinic, is introduced to AM and his mom, and then begins his appointment. Similar to a face-to-face encounter, the psychiatrist obtains a detailed history while observing the child. With the psychiatrist’s observations, a comprehensive history, and teacher/parent reports, a detailed understanding of the child evolves. The telepsychiatrist discusses his findings with AM’s mom and they review treatment options.

Prior to the existence of telemental healthcare (TMH), AM’s treatment would have been constrained by distance and a dearth of providers. Limited resources, long travel times, high travel expenses, unreliable transportation and provider shortages previously rendered this family unable to find care. TMH has changed the lives of people like AM. Establishing a successful, patient-oriented TMH practice requires careful consideration of several aspects. Some features are intuitive because they are no different from face-to-face appointments, but others are unique to telepsychiatry. Based on seven years of personal experience as a telepsychiatrist and a review of the literature, I have compiled a list of some key considerations when developing a TMH practice.

Space

Room size, décor, and design are critical when developing TMH clinics. The space must be suitable for the clinician to observe parent and child interactions. The patient must be able to stand, sit, wave, walk, and move during the appointment. The room needs to have enough space for at least one adult to sit next to the child and be visible on camera. A room that is too large, or filled with extraneous equipment, may be distracting or over stimulating to the child (AACAP 2008, ATA 2009b).

Bandwidth

Teleclinicians rely on observation of patients’ movements, affect, and communication for diagnostic evaluation and treatment decision-making. In order to accurately replicate face-to-face evaluations, there must be high bandwidth (384 Kbits/sec) and monitor resolution (> 30 frames/second) (AACAP 2008, American Telemedicine Association [ATA] 2009b, ATA 2013). Adequate bandwidth facilitates detection of affective state and withdrawal, mild tremors, tics, fine motor control, and neuroleptic-induced abnormal movements. Sufficient bandwidth minimizes the time lapse in verbal transmission, allowing the patient and teleclinician to freely converse and any anomalies of speech and prosody become evident. Insufficient bandwidth produces pixilation of the video signal and delay of the audio signal so that the teleclinician and patient interrupt one another, impeding the mental status examination (Glueck 2013).

Camera

Cameras have a crucial role during telehealth appointments. The task demand and bandwidth influence camera choice. Careful camera placement enables providers to easily observe participants and activity in the exam room. If a provider can remotely control the tilt, pan, and zoom (TPZ) functions to view the patient, the provider’s power of observation is heightened (AACAP 2008, ATA 2009b, ATA 2013). Having TPZ controls to view the provider’s side enables families to take a virtual tour of the provider’s office and feel more connected to the provider (AACAP 2008, ATA 2009b, ATA 2013). With TPZ ability, the provider may use the camera to play “hide and seek” with children (Glueck 2013).

Placing the camera directly in front of the patient at eye level maximizes eye contact. Putting the monitor either higher or lower on the wall guides the patient and provider to have more natural eye contact. Currently many telehealth set-ups have the camera above, below, or to the side of the monitor. This placement produces a gaze that appears to have a person looking down, up, or sideways, respectively (AACAP 2008, ATA 2009b, ATA 2013). Since teleclinicians must look at the patient, the camera and the medical record during visits, the provider’s gaze is often diverted, leading the patient to think that the provider is not paying attention. An ideal system enables the provider to maintain eye contact with the patient at all times. Several solutions exist to solve this problem. By focusing the camera above mid chest some notes may be taken without an interruption in eye gaze, if the provider is able to write or type without looking. Unfortunately zooming in on the provider distorts the patient’s perception of the clinician. An alternative set up uses two monitors placed close together to minimize changes in eye or head position. Figure 1 shows a novel set up with the monitors placed vertically and a camera in the middle. There is less head movement as the teleclinician looks up and down and his/her gaze passes the camera.

Toys/Artwork

Children can draw pictures and share with the provider. These pictures may shed insight into the child’s thoughts and feelings. This author worked with a

continued on page 284
site that let children use a nonfunctioning keyboard so they could type “just like the doctor.” Children like to bring a favorite toy and show it to the teleclinician. Some toys should be at the patient site so the provider can observe the child playing and occupy the child while adults talk. Noisy toys will interfere with auditory communication and toys with many parts will provide a cleanup burden for staff.

Sound Quality
Successful TMH sessions are predicated on quality sound production and transmission. Dropped signals, dys synchrony with the video signal, and echo interference all hinder the provider/patient relationship. Microphones should not transmit ambient noise but be able to detect quiet voices. Placing carpeting on the floor, draperies on the windows, and sound panels or textiles on the walls improves sound quality and softens hard surfaces. A sound machine outside the room decreases interference from outside noise and increases auditory privacy (AACAP 2008, ATA 2009b, ATA 2013).

Picture in Picture
A unique feature of videoconferencing is the “picture in picture” (PIP) function. A small box in the corner of the monitor shows the teleclinician how he/she appears to patients and vice versa. Teleclinicians may use the PIP function to see how they and their background appear, and to note their affective responses to the patient (AACAP 2008, ATA 2009b, ATA 2013). Children and adolescents enjoy seeing themselves on camera.

Conclusion
Telemental healthcare is a promising service delivery model to provide mental health care to children and adolescents who do not have access to usual models of mental healthcare. Conducting an accurate evaluation, providing evidence-based care, and achieving effective outcomes all via telehealth requires consideration of the technology, space, and system design. To ensure success, stakeholders must champion TMH by educating families, community members, and providers about its value.

References

Dr. Goldstein is medical director of Lee Specialty Clinic in Louisville, Kentucky and a member of the AACAP Telepsychiatry Committee. She may be reached at FelissaGoldstein@admed.us.
Committees

ACACAP Advocacy and Collaboration Grants

Coalition building is key to any successful grassroots advocacy campaign. Simply stated, allied organizations are more effective when working together towards a common goal. Joining with other stakeholders allows for an exchange of ideas and sharing of resources. This can lead to a more distinct and persuasive message, a demonstration of consensus, and ultimately a greater impact on shaping health care policy. In an effort to support coalition building at the local and state level, AACAP continues to offer Advocacy and Collaboration Grants to our regional organizations.

The Advocacy and Collaboration Grant Program is offered through the American Association of Child and Adolescent Psychiatry with the support of the Department of Government Affairs and the Assembly Executive Committee. Grants in the amount of $3000 are awarded annually to regional organizations. To qualify, regional organization’s advocacy must be designed to improve children’s mental health care, and collaboration between regional organizations and allied organizations is required.

In 2016, AACAP awarded seven grants to the following regional organizations: Colorado, Maine, Minnesota, Nebraska, Nevada, North Carolina, and New York. Congratulations to all participants for developing innovative and meaningful programs.

“The AACAP Advocacy Grant allowed the psychiatric community in Omaha to partner with community advocacy organizations, the academic community and students across many health disciplines and began a dialogue on the need for everyone to be engaged in reducing violence. Students were given the opportunity to meet with community organizations (Big Brothers and Big Sisters, CASA, NAMI among others) to explore volunteer opportunities.” – Kayla Pope, MD, JD, Director of Neurobehavioral Research at Boys Town National Research Hospital.

Now is the time to start planning for 2017. Regional organizations are encouraged to apply for the upcoming AACAP Advocacy and Collaboration Grants. Deadline for applications is January 13, 2017. Advocacy programs must be designed to improve children’s mental health care and be developed with other allied organizations. Activities must be completed within the calendar year in which the grant was awarded. While it is possible to develop programs that will inform mental health policy, grants cannot be used for lobbying. Inquiries can be directed to the Government Affairs team at gov@aacap.org.

Share Your Photo Talents With AACAP News

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

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

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

Alvin Rosenfeld, MD
Photo Editor, AACAP News
arosen45@aol.com
2016 AACAP Virginia Q. Anthony Outstanding Woman Leader Award: Gabrielle A. Carlson, MD

Gabrielle A. Carlson, MD

I am very grateful to Gregory Fritz, MD, and AACAP for the 2016 AACAP Virginia Q. Anthony Outstanding Woman Leader Award. Being acknowledged by my profession for leadership in general makes me very proud. Attaching it to being a woman is even more special.

I chose to go to an all women’s college (Wellesley) precisely because I wanted to be educated in a place where female leadership was prized. Girls with a brain in public high school were not cool in my day. Spending four years with all women classmates was not nearly as much of a challenge as going from being “top dog” in high school to scrabbling for “lucky to be average” in college. Besides, I figured there would be plenty of men around in medical school to which I had long intended to go.

Indeed, at Cornell, I was one of five women in a class of 86 students. I chose Cornell for a reason that has guided many important decisions. All other things being equal, I like places where the leaders are basically nice people. The person who interviewed me, Dr. Tom Meikle (who ultimately became the medical school’s dean), was very nice and made Cornell feel appealing. As it turned out, he took good care of me and made sure my male lab partners were a decent group of guys. That was a good thing, for although most of my male classmates were respectful, a few were obnoxious. So, lesson #1 – if leadership is kind and respectful, it sets an important tone.

Being a minority had its pluses. I have been life-long friends with my first roommate, and I married one of my lab partners, who became my second roommate. As many of you know, Harold has been the wind beneath my wings for my whole married life. So lesson #2 is, if you are going to have a partner, make sure it is someone with whom you can enjoy your successes and who will support you in failures.

I was the only woman in over 50 house staff at Jewish Hospital (part of Barnes-Jewish) in St. Louis. As a testimony to how oblivious I was, I did not realize that fact until I took a good look at the house staff pictures many years later. I was oblivious due to lesson #3. I have always worked closely with nurses. They have been great colleagues and have saved my behind more often than I care to admit, so I never felt alone. The team is important.

Fast forward to training at the National Institute of Mental Health (NIMH). I was the first woman clinical associate at the Clinical Center, in Bethesda. This was novel enough at the time that the clinical director was flustered about how I would take night call as I would be “sleeping in the same bed as the male clinical associates” (albeit not at the same time). I was indignant that I would be viewed differently from the guys. If I had had my wits about me, I would have offered not to take night call. It has always been important, though, not to have people cut me slack because of gender.

My time at NIMH was the first time that I realized that the “only woman” registered with me. Four things saved the day. Though female nurses and the social worker, like the clinical director, did not know quite what to make of me because the public health service doctors had always been men, these non-physician colleagues were experienced observers and clinicians who made my experience fun and educational, and got me through many a rough spot. I also met a patient, a young man with severely psychotic mania who basically changed my life by sparking a clinical research question about the nature of mania versus schizophrenia in youth. This inspired me to go into child and adolescent psychiatry to learn more about developmental psychopathology. Dr. Fred Goodwin, my unit director, on his way to becoming a major force in mood disorders research, did two things for me. He challenged the difference of opinion we had about the aforementioned patient by making me do the research to test my hypothesis. When I proved I was right (which clearly surprised him), he was man enough to admit it and supported me rather than squelching me. Not all leaders do that with their protégé. So lesson #4 – work for people who give you a hand up the ladder of success, not someone who stomps on your hand until you give up and let go. The final day saver was Judy Rapoport, MD. She does not know it, but having a scientist and woman child and adolescent psychiatrist in a leadership position provided me with an important role model. Mind you, role models do not have to take you on their knees. It is simply comforting and liberating knowing that certain possibilities are available.

Doing child and adolescent psychiatry training at UCLA was also a “person” decision. My training at Washington University in St. Louis and NIMH made me an appealing fellowship candidate to Dr. Denny Cantwell, a well-known St. Louisianan and clinical researcher. I was at crossroads deciding where to go next for training. Harold had narrowed the choices down to four places based on offers he had received. Denny took the time and trouble to telephone me and make me feel wanted and valued. That was so important! For those of you who knew Denny, no other explanation is needed. He was really smart, a great clinician and thinker, and a real character. When he told a joke, it was like “Click and Clack, the Tappet Brothers”
CALL FOR NOMINATIONS

AACAP’s Nominating Committee is presently soliciting names for nominations for President-Elect, Secretary, Treasurer, and Councilor at Large positions. The deadline for nominations is February 1, 2017. Nominations should be sent directly to executive@aacap.org.

If you wish to recommend someone for a position, please send the following to executive@aacap.org by February 1, 2017:

■ A letter of interest from the candidate with an indication of the office(s) of interest to that person
■ Candidate’s current CV
■ Candidate’s Disclosure of Affiliations Statement

If you wish to recommend yourself, please send the following to executive@aacap.org by February 1, 2017:

■ A letter of interest with an indication of the office(s) of interest
■ Your current CV
■ Your Disclosure of Affiliations Statement

Nominating Committee
Nominating Committee Chair
Paramjit T. Joshi, MD
pjoshi@cnmc.org

Nominating Committee Members
Kathleen Kelley, MD
kelley@psych.uic.edu
Sharon Hirsch, MD
shirsch37@gmail.com
James Hudziak, MD
james.hudziak@uvm.edu
Bonnie Zima, MD
bzima@mednet.ucla.edu

*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.

Dr. Carlson is professor of Psychiatry and Pediatrics at Stony Brook University School of Medicine in Stony Brook, New York. She may be reached at Gabrielle.Carlson@StonyBrook.edu.
Did You Hear That? Help for Children Who Hear Voices

Seetha Subbiah
World Scientific Education 2016
Paperback: 160 pages – $18.50

Did you Hear That? Help for Children Who Hear Voices is an illustrated therapeutic storybook about hallucinations in children. Organized into six short chapters, the book follows five children and their unique experiences with visual and auditory hallucinations. Their stories help to normalize the experience of hallucinations and dispel a number of myths a child may have about therapy.

Chapter 1 tells the story of Susie, a nine-year-old girl who sees and hears the voice of a pirate when she struggles with decisions or fears making mistakes. Susie finds relief as she works with her therapist to understand the origin of the hallucinations, including the strong connection with early abuse by her biological father.

The next story is about Carlos, a 6-year-old boy, whose auditory and visual hallucinations of a fire-blowing dragon and a witch began after his parents’ divorce. His hallucinations improve as he works through his feelings of guilt and anger with a therapist.

Selma is a 15-year-old girl who sees three girls. She initially found these entities entertaining, but soon the arguments among them became distracting. Her hallucinations began after she was placed in foster care and was separated from her sister.

Chang, a 12-year-old boy, also began to hear a voice highly critical of him not long after he was placed in his grandparents’ care after his mother’s struggle with schizophrenia left her unable to care for him. The support of his grandparents and guidance of a counselor helped him.

The last story is about a four-year-old toddler Leila, who sees and hears her recently deceased mother. The book describes her hallucinatory experiences as comforting and as a way for her to remain connected to her mother.

The final chapter brings the stories together and reviews basic principles of managing hallucinations in children. Management is limited to individual therapy and largely focuses on helping co-create a narrative with the child about the significance and origins of the hallucinations. Additionally, each child develops his/her own “trick” to utilize when bothered by hallucinations.

Throughout the book, Susie, the young girl in the first chapter, offers brief narrations and insights. Her questions are dispersed throughout the chapters and emphasize important concepts and facilitate further discussion. Emotions are highlighted with bold and colorful text.

Bright and colorful illustrations bring the stories to life even more vividly.

Did You Hear That? Help for Children Who Hear Voices is an ambitious storybook that attempts to tackle the challenge of dealing with and managing hallucinations in children. It is a valuable resource for families and helps normalize the experience of hallucinations and its appropriate management. The book tells the stories of children whose ages range from 4 to 15; and given its illustrations, it is particularly suitable for young children. The management section discusses the value of family support and efficacy of individual therapy, but not medications. [Question to the author – do you think discussing hallucinations in teenagers, and hallucinations in children with schizophrenia with parents, the therapist should at least mention medication?]
DSM-5 Casebook and Treatment Guide for Child Mental Health

Edited by Cathryn A. Galanter, MD, and Peter S. Jensen, MD
American Psychiatric Association
Publishing 2017
Paperback: 452 pages – $79.00

DSM-5 Casebook and Treatment Guide for Child Mental Health is a new offering from APA Publishing well-suited for clinicians and students. Organized by cases, the book presents key principles of evidence-based assessment and treatment in child and adolescent mental health. Written by experienced clinicians (e.g., psychiatrists, psychologists, social workers, pediatricians, and nurses), each case is realistic and highlights common challenges faced by everyday providers. All cases are accompanied by expert commentaries, considering psychotherapeutic and psychopharmacological perspectives of assessment and management.

The book begins by describing the general organization of the casebook and how the editors and contributors approach and conceptualize cases. Each case is presented in a systematic fashion, reviewing identifying information, chief complaint, and history of present illness, including past psychiatric, medical, developmental, social, and family histories. Mental status exams as well as helpful reviews and discussions of relevant rating scales and structured assessment measures are also included.

Each case offers a psychotherapeutic and a psychopharmacological perspective by leading experts in the area. These discussions include a review of diagnostic formulations, including DSM-5 diagnoses, suggested diagnostic assessment tools, and treatment recommendations. Each case ends with numerous references.

Part I presents 12 classic cases, such as attention-deficit hyperactivity disorder, autism spectrum disorder, separation anxiety, selective mutism, major depressive disorder, bipolar disorder, chronic marijuana use, psychosis, anorexia nervosa, Tourette’s syndrome, disordered sleep, and obsessive compulsive disorder.

Part II focuses on 7 cases with comorbid complexity, including disruptive behavior in an adolescent, threats to harm a teacher, misuse of prescription medications, multiple anxiety disorders, rage attacks, language and reading difficulties, and irritable bowel syndrome.

Part III presents 5 cases, such as oppositional behavior in a young child, a dysregulated preschool child, clinical high risk of developing psychosis, non-suicidal injury, and psychotic symptoms in a child who is a victim of neglect.

Part IV highlights 5 cases of children in crisis including depressed mood in a child in foster care, irritability and anger in a refugee, depression in the context of divorce, childhood bereavement, and disinhibited attachment in a toddler.

Part V concludes with chapters focused on diagnostic decision-making and the future of treatment decision-making based on research and expert clinical perspective.

DSM-5 Casebook and Treatment Guide for Child Mental Health is a great resource for clinicians and students of child and adolescent mental health. With 29 cases of varying difficulty, even the most experienced practitioner will find this book valuable. The case-based format is well-done and the consistent organization of each chapter allows for easy navigation and quick reference. The comprehensive discussion of psychotherapeutic and psychopharmacological principles provides a unique opportunity to learn how leaders in the field approach realistic clinical scenarios.

AACAP members who would like to have their work featured on the Media Page may send a copy and/or a synopsis to the Resident Editor, Erik Loraas, MD, 3811 O’Hara Street, Pittsburgh, PA 15213, or by e-mail to loraasek@upmc.edu.
Poetry

Dance.

Listen to the pagan Celtic music rhythms as they beat a steady pace upon our hearts and souls.

Listen to the caressing fairy winds blowing maybe somewhere near but far as they mix sound words with the Seanachai* seer.

For there is a poetry and music in our souls waiting to be released upwards outwards shaping life’s realities.

Let us dance to the music within our bodies our spirits our lives.

Let us dance to the moon to the sun the rain the wind.

Dance with the day’s night night’s day, as we did in times before we met but now dance with life’s memories into the Blazing Light.

~ Kieran D. O’Malley, MD, June 18th 2014, the train from Dublin to Cork.

Inspired by a Lakota saying; “Dance the music of the living and the dead, and you will find your way home.”

* Irish storyteller.
Knowledge is Power

AACAP Facts for Families

AACAP Facts for Families are fact sheets that provide concise, up-to-date information on issues that affect children, teenagers, and their families. AACAP currently has 120 fact sheets that are a great resource for doctors, patients, parents, schools, clinics, and others!

Visit www.aacap.org to harness the power of our resources today!

TOP 5
1. Video Games and Children: Playing with Violence
2. Oppositional Defiant Disorder
3. Teen Suicide
4. Teen Brain: Behavior, Problem Solving, and Decision Making
5. TV Violence and Children

There’s strength in numbers, so share what you know!
On the Value of Our Medical Training

Many years ago, I was killing time in the Emergency Department at a large metropolitan county hospital, waiting for the next psychiatric patient to be brought in. I was then a second year resident, rotating through the very active and acute county emergency service as part of my university’s general psychiatric training program. Wanting to deal both with my boredom and to be supportive, I made an effort to engage a new intern on the medical service in conversation. He appeared to be anxious. He was concerned about a patient of his, and his supervising resident was nowhere to be seen. I said hello to him and wondered out loud that while it might be hard for him to believe, as I was simply a psychiatrist-in-training, if he were aware that I could interpret dreams—yes, even the dream that his patient was then having. And I could do this despite the fact that I had never known or dealt directly with his young adult male patient who was lying unconscious on a gurney 20 feet away.

It was hard for the intern to believe that I had such powers, so I became determined to prove it to him. Though almost entirely unresponsive to external stimuli, his patient appeared to be restless, rocking slightly from side to side. I told him the young patient dreamt he was in the second grade in school and desperately felt the need to urinate. And I could do this despite the fact that I had never known or dealt directly with his young adult male patient who was lying unconscious on a gurney 20 feet away.

The intern expressed disbelief! I therefore told him to go back to his patient, and when he got there, instructed him to palpate his bladder. I predicted that he would find it very likely extended up to the umbilicus. Perhaps, partly to humor me, he did. Astonished, he came back a few of minutes later asking how could I have known that the bladder was full, seemingly to the bursting point. How could I know and understand the dream of an unconscious patient, especially one to whom I had never spoken or even gotten physically close to?

I decided it best not to answer any of those questions. What I did instead was suggest that he catheterize his patient and then very slowly decompress the bladder, and the next time he decides to administer IV fluids to an unconscious patient, he might also think about inserting a catheter.

I never saw that intern again. But half a century later, I continue to be impressed over and over again with what we as psychiatric physicians can discern and how helpful we can be due to our unique experiences. I appreciate that our abilities are complexly determined. Certainly, some come out of our formal training, which gives us knowledge of such things as the importance of a biopsychosocial formulation, psychology, physiology, pharmacology, child development, diversity issues, trauma studies, and the like. Additionally, some undoubtedly come from a self-selection process that, consciously or not, leads us to choose to be physicians and then psychiatrists. Still others come from specific experiences we have in medical school.

Physicians are unique. Few others are given permission to put their hands into every bodily orifice, or to take a blade to cut open a living person in order for us to see and feel the different cavities that house our patients’ various organs, to deliver a baby, or to sit with a person who is in the process of dying.

I strongly believe these experiences sensitize us to the vast range of issues our patients bring when they come to us for relief from their psychic suffering. In addition to this sensitization, these experiences also serve to help us have the strength to deal with our patients simultaneously with sympathy, empathy, and objectivity.

Dr. Levin is a Distinguished Life Fellow. He practices in Berkeley, California, and may be reached at eclevin@earthlink.net.
We’ve got you covered.

For over 30 years, we have provided psychiatrists with exceptional protection and personalized service. We offer comprehensive insurance coverage and superior risk management support through an "A" rated carrier.

ANNOUNCING NEW ENHANCEMENTS TO THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY PROFESSIONAL LIABILITY PROGRAM:

• Defense Expenses related to Licensing Board Hearings and Other Proceedings: Increased Limit to $50,000 per proceeding with NO annual aggregate (higher limits are available up to $150,000)

• Fire Legal Liability Coverage: Limit of liability increased to $150,000 for fire damage to third party property

• Emergency Aid Coverage: Reimbursement up to $15,000 in costs and expenses for medical supplies

• Insured's Consent to Settle is now required in the settlement of any claim – No arbitration clause!

• First Party Assault and Battery Coverage: Up to $25,000 reimbursement for medical expenses related to injuries and/or personal property damage caused by a patient or client

• Medical Payments Coverage: Increased limit to $100,000 for Medical Payments to a patient or client arising from bodily injury on your business premises

IN ADDITION WE CONTINUE TO OFFER THE FOLLOWING MULTIPLE PREMIUM DISCOUNTS:

• 50% Resident-Fellow Member Discount

• Up to 50% New Doctor Discount (for those who qualify)

• 50% Part Time Discount for up to 20 client hours a week or less

• 10% New Policyholder Discount (must be claims free for the last 6 months)

• Discounted Rate applies for those whose patient base is more than 50% Children and Adolescents

• 10% Claims Free Discount for those practicing 10 years, after completion of training, and remain claims free

• 5% Risk Management Discount for 3 hours of CME

(Above Coverage Features and Discounts are subject to individual state approval)

Visit us at apamalpractice.com or call (800) 421-6694 x-2318 to learn more.

SPONSORED BY:
American Academy of Child & Adolescent Psychiatry
WWW.AACAP.ORG

American Professional Agency
Leaders in Psychiatric Medical Liability Insurance
Call for Papers

AACAP’s 64th Annual Meeting takes place October 23-28, 2017, at the Marriott Wardman Park and Omni Shoreham in Washington, DC. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by Wednesday, February 15, 2017, or by Thursday, June 15, 2017, for (late) New Research Posters. The online Call for Papers submission form will be available at www.aacap.org in December 2015, and all submissions must be made online.

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

Session Recordings and Notebooks are available for purchase from past and current AACAP meetings!

- Pediatric Psychopharmacology Update Institute
- Hansen Annual Review Course
- Annual Meeting Institutes and other sessions

For a complete list, visit the Past Meeting Resources and Publications page at www.aacap.org/cme_and_meetings. Session recordings include PowerPoint slides.

To order, please visit: aacap.scliffelearningcenter.com or contact:

Multiview
7701 Las Colinas Ridge, Suite 800
Irving, TX 75063
Phone: 972.402.7098
Fax: 972.402.7035

To order Notebooks:
Order online through the Publication Store at www.aacap.org.
Questions? Call: 202.966.9574
MEETINGS

Call for Exhibitors!

Reserve your space now to exhibit at AACAP’s annual Institutes. We offer tabletop exhibits to allow exhibitors the chance to connect with specific demographics within the child and adolescent psychiatry community. Approximately six tabletop exhibits are available at each meeting and are placed in high-traffic areas, providing exhibitors with the greatest opportunity to meet attendees. The vast majority of our attendees are practicing physicians. Exhibit opportunities are below:

2017 Pediatric Psychopharmacology Update Institute: Psychopharmacology Treatments From Childhood Through Transitional Age
Gabrielle A. Carlson, MD, and Manpreet Kaur Singh, MD, MS
January 20-21, 2016
The Westin St. Francis San Francisco
San Francisco, CA
Expected Attendance: 550+

Douglas B. Hansen, MD, 42nd Annual Review Course in Child and Adolescent Psychiatry
Gabrielle A. Carlson, MD, and Mary Margaret Gleason, MD, Co-Chairs
March 18-20, 2017
Royal Sonesta New Orleans
New Orleans, LA
Expected Attendance: 200+

The Invitation to Exhibit for AACAP’s 64th Annual Meeting, October 23-28, 2017, at the Marriott Wardman Park and Omni Shoreham will be mailed in May.

For more information, please visit www.aacap.org/ExhibitandSponsor or contact:
Brooke Schneider
AACAP Meetings and Exhibits Manager
Phone: 202.966.9574
Fax: 202.966.5894
E-mail: exhibits@aacap.org

SPECIAL PROMOTION

Order Module 13 when you pay your 2017 membership dues by January 31, 2017, and SAVE $60!
Look on your dues renewal form for more information.

AACAP’s Newest Lifelong Learning Module Now Available

AACAP is proud to announce the upcoming release of Lifelong Learning Module 13: Relevant Clinical Updates for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 38 AMA PRA Category 1 Credits™ (8 of which will count towards the ABPN’s self-assessment requirement).

To order Module 13:
Online: Purchase via our online publication store at www.aacap.org.
By Fax/Mail: Download and print a publication order from www.aacap.org/moc.
By Phone: Call 202.587.9675 to place your order over the phone.

For questions about Module 13 or maintenance of certification, please contact Quentin Bernhard III, CME Manager, at 202.587.9675 or at qbernhard@aacap.org.

Session Recordings and Notebooks are available for purchase from past and current AACAP meetings!
We have what you’re missing.

Recordings and Notebooks are now available for purchase from past and current AACAP meetings.

With these educational resources, you can:

- Review best practices on topics such as psychopharmacology, treatment, issues in practice, and much more
- Continue your professional development
- Catch up on AACAP education that you missed

Session recordings include PowerPoint slides. For a complete list, visit the Past Meeting Resources and Publications page at www.aacap.org/cme_and_meetings.

To order recordings:
Visit aacap.sclivelearningcenter.com or contact Multiview at 972.402.7098

To order Notebooks:
Membership CORNER

Pay Your Dues Online

Did you know that the Members-Only section of the AACAP website provides valuable information regarding member issues and can save time and effort by providing you with the tools to manage your account? By logging into www.aacap.org, you can:

- Pay dues online
- View/Edit your profile
- Update your Member Directory listing
- Reset your password or change your login information
- Purchase publications

For all questions regarding your membership, contact membership@aacap.org.

We’re here to help!

Need help making your dues payment? Contact us to discuss flexible installment payment options.

2016 September/October Cover

Credit: Alan Sandler, MD

CORRECTION: Please know that the cover photo for the 2016 September/October issue was incorrectly credited — the wonderful photo was taken by Alan Sandler, MD. Dr. Sandler, please keep the amazing photos coming our way!

Description: “The Organ Grinder’s Daughter

“An organ grinder, his picture perfect little lady, and her birds at the open-air market in Porto, Portugal, taken while traveling on my way to the AEPNYA 60th Congress – a shared initiative with AACAP, in Donostia/San Sebastian, Spain.”

– Alan Sandler, MD
Congratulations to the 2016 New Distinguished Fellows!

Khalid Afzal, MD, Hickory Hills, IL
Lisa Amaya-Jackson, MD, MPH, Durham, NC
Alka Aneja, MD, San Ramon, CA
Renu Anupindi, MD, Austin, TX
Dana Arlien, MD, Reno, NV
Julie Balaban, MD, Lebanon, NH
Sharon Cain, MD, Kansas City, KS
Richard Camino Gaztambide, MD, MA, Macon, GA
Lee Carlisle, MD, Tacoma, WA
Daniel Connor, MD, Farmington, CT
Sergio Delgado, MD, Cincinnati, OH
Robert Dicker, MD, New Hyde Park, NY
Daniel Dickson, MD, East Providence, RI
William Dikel, MD, Minneapolis, MN
Susan Donner, MD, Woodland Hills, CA
Julius Earle, MD, Greenville, SC
Ken Ensroth, MD, Oregon City, OR
Jean Frazier, MD, Boston, MA
Daniel Geller, MD, Newton, MA
Jaswinder Ghuman, MD, Sewickley, PA
Lisa Giles, MD, Salt Lake City, UT
Kevin Gray, MD, Charleston, SC
Rosalie Greenberg, MD, Summit, NJ
Katherine Grimes, MD, MPH, Cambridge, MA
Jennifer Hagman, MD, Aurora, CO
Usman Hameed, MD, Hummelstown, PA
Stephanie Hartselle, MD, Providence, RI
Emmeline Hazaray, MD, Northbrook, IL
Claudine Higdon, MD, Glen Oaks, NY
Michelle Horner, DO, Ellicott City, MD
Ray Hsiao, MD, Seattle, WA
Vivian Kafantaris, MD, Glen Oaks, NY
Kristopher Kaliebe, MD, Tampa, FL
Sheryl Kataoka, MD, Los Angeles, CA
Robert Klaehn, MD, Chandler, AZ
Matthew Koury, MD, MPH, Newport Beach, CA
Jennifer Le, MD, Louisville, KY
Patricia Leebens, MD, New York, NY
Howard Liu, MD, Omaha, NE
David Lopez, MD, Kew Gardens, NY
Catherine Martin, MD, Lexington, KY
Jeremy Matuszak, MD, Reno, NV
John McCarthy, MD, Troy, NY
Bruce Miller, MD, Buffalo, NY
Dorothy O’Keefe, MD, Mechanicsville, VA
Nnenna Kalaya Okereke, MD, Roanoke, VA
Roberto Ortiz-Aguayo, MD, Pittsburgh, PA
Scott Palyo, MD, New York, NY
Renuka Patel, MD, Saint Louis, MO
Rodrigo Pizarro, MD, New York, NY
Sigita Plioplys, MD, Chicago, IL
Kayla Pope, MD, Omaha, NE
Nicholas Putnam, MD, Encinitas, CA
Dhana Ramasamy, MD, Allentown, PA
Kenneth Rogers, MD, Greenville, SC
Anthony Rostain, MD, Philadelphia, PA
Robert Sahl, MD, Avon, CT
Duru Sakhrani, MD, Dardenne Prairie, MO
Daniel Schechter, MD, Geneva, ???
Benjamin Shain, MD, PhD, Highland Park, IL
Scott Shannon, MD, Fort Collins, CO
Heather Shibley, MD, Hubert, NC
Norbert Skokauskas, MD, PhD, Trondheim, Norway
Hanna Stevens, MD, PhD, Iowa City, IA
Frederick Stocker, MD, Anchorage, KY
Shayla Sullivan, MD, Kansas City, MO
Eva Szigethy, MM, PhD, Pittsburgh, PA
James Waxmonsky, MD, Harrisburg, PA
Deborah Weisbrot, MD, Stony Brook, NY
John Wilkaitis, MD, MBA, CPE, MS, Jackson, MS
Michel Woodbury-Farina, MD, San Juan, PR
Albert Zachik, MD, Potomac, MD
Linda Zamvil, MD, Morrisville, VT
Welcome New AACAP Members

Elham Abbas, MBBS, Kansas City, KS
Shibly Abraham, MD, Bellerose, NY
Thomas Adams, Chicago, IL
Olurotimi Adejumo, MD, Ibadan, Oyo State, Ibadan, Nigeria
Lisa Adler, MD, Washington, DC
Mawuena Aghonyitor, MD, Dallas, TX
Shilpa M. Agraharkar, MD, New York, NY
Ireen Ahmed, MD, Boston, MA
Adefolake Akinsemen, MD, Cleveland, OH
Tahani Alqassem, MD, Jeddah, Saudi Arabia
Michelle Alstrom, MD, Brooklyn, NY
Alcides Amador, MD, Houston, TX
Tomeika Anderson, DO, Cincinnati, OH
Ali Anwar, MD, St. Louis, MO
Nicholas Arnouldse, Temple, TX
Sarah H. Arshad, MD, Pittsburgh, PA
Joshua Atkinson, MD, San Antonio, TX
Brittany Atuahene, Pittsburgh, PA
Meena Azizi, MD, Hикsville, NY
Pratik Bahkar, MBBS, Jersey City, NJ
Shivnavleen Bains, MD, Mc Kees Rocks, PA
Dustyn Baker, Jackson, MS
Danielle Barcak, New York, NY
Eric Barker, MD, Lebanon, NH
Carina Behrens, MD, Cincinnati, OH
Amina Belaïfa, MD, Birkhadem, Algiers
Lauren Bell, Brooklyn, NY
Anthony Belotto, MD, Bethesda, MD
Mary Belton, MD, Dublin, ????
Dorit A. Ben-Ami, MD, Southfield, MI
Sabina R. Bera, MD, MSc, Bakersfield, CA
Seth Berger, MD, New York, NY
Aaron Besterman, MD, Los Angeles, CA
Hannah Betcher, MD, Rochester, MN
Joseph Biedrzycki, DO, Liverpool, NY
Mina Boazak, MD, Atlanta, GA
Joseph B. Bond, MD, Lebanon, NH
Dalton Bourke, Omaha, NE
Dana Bradley, MD, Pearlard, TX
Jorien Breur, MD, San Francisco, CA
Frances Broghammer, Long Beach, CA
Daniela Marecella Bromberg, MD, Cleveland, OH

Matthew Brown, DO, Worcester, MA
Anna Butler, MD, FRCP, Waterdown, ON
Alicia T. Carlos, DO, Lexington, KY
Metin Cayiroglu, MD, New York, NY
Brittany Cerankosky, MD, Cincinnati, OH
William Cerrato, DO, Easton, MD
Clarice Chan, MD, Glen Oaks, NY
Serena M. Chang, MD, New York, NY
Janet Chaoreshook, MD, Pocoma, CA
Tingfang Chen, MD, Lansdale, PA
Lawrence Chiu, MD, Houston, TX
Jason Cho, MD, Durham, NC
Sharic Cid Colon, MD, Brooklyn, NY
Sharonnda Nicole Clark, MD, Houston, TX
Shana Clarke, MD, Brooklyn, NY
Adia Cobb, MD, Philadelphia, PA
Cory D. Coldwell, MD, Plano, TX
Vanessa Carolina Cordero, MD, Viña Del Mar, Chile
Hadia Cridor, MD, Columbia, MO
Aaron Crum, MD, Aurora, CO
Christina Cruz, MD, Chapel Hill, NC
Jessica Cummings, MD, Memphis, TN
Desdemona Curtis-Downes, MD, New Providence, Nassau
Eboni Davis, MD, New York, NY
Lauren Deaver, Brandon, MS
Melissa DeFilippis, MD, Galveston, TX
Susane Dickson, MD, Decatur, GA
Miriam Dickson, MD, Oak Park, IL
Katharine Dinwiddie, DO, Dallas, TX
Swati Divakarla, MD, Philadelphia, PA
Allen Dsouza, MD, West Orange, NJ
Stacey Elengickel, Bellingham, NY
Alaa Elnajjar, MD, Valhalla, NY
Caitlin Engelhard, MD, Baltimore, MD
Zachary Engler, MD, Providence, RI
Nicholas Evangelidis, MD, Manhattan, KS
Pouria Farhoomandi, MD, Carle Place, NY
Zu Fashan, MD, Brooklyn, NY
Michael L. Feldmeier, MD, Portland, OR
Fernando Felix, MD, Aguascalientes, Mexico
Dara Fernandez, MD, Flushing, NY
Christian Fleischhaker, MD, Freiburg, Germany
Teresa D. Flower, FRANZCP, Hawthorn, Victoria, Australia

Marie Fournier, MD, Montreal, QC
Yuli Fradkin, MD, Montclair, NJ
Meghan Gaare, MD, Charlottesville, VA
Dora Galvis, MD, Bogota, Colombia
Samuel Gartner, MD, Great Neck, NY
Ambreen Ghori, MD, Cleveland, OH
Sarah Gibbons, MD, Buffalo, NY
Jasleen Gill, MD, Rego Park, NY
Mohsin Khan, MD, Richardson, TX

FOR YOUR INFORMATION

continued on page 284
Welcome New Members continued from page 299

Yopi Sarah Kim, DO, Edison, NJ  
Benjamin Orlando Klass, MD, New York, NY  
Ana Kleinman, MD, Sao Paulo, Brazil  
Malliha Kucheria, MD, Somerset, NJ  
Yael Kufert, MD, New York, NY  
Maani Kumar, MD, Jamaica, NY  
Jasmin Lagman, MD, Philadelphia, PA  
Laura J. Lai, MD, Irvine, CA  
Johanna Landinez, MD, Louisville, KY  
Rupinder Legha, MD, Los Angeles, CA  
Alison Lenet, MD, New York, NY  
Kenneth Lin, MD, Cincinnati, OH  
Cecilia Lipira, MD, Brooklyn, NY  
Michelle Liu, MD, New York, NY  
Laura Lockwood, DO, Birmingham, AL  
Yolanda Lopez, MD, San Pablo, Heredia, Costa Rica  
Janeris Loredo, MD, Grovetown, GA  
Jenna Margolis, Scarsdale, NY  
Asha Martin, Linden, NJ  
Rogelio Martinez, II, MD, Rockville, MD  
Fatima Masumova, DO, East Norwich, NY  
James McAuliffe, FRANZCP, Windsor, QLD  
Fernando Mendez, MD, Kansas City, KS  
Bejamin Merotto, MD, New York, NY  
Akos Mersch, MD, Denver, CO  
Ben Milczarski, MD, Syracuse, NY  
Rebecca Miller, MD, Pittsburgh, PA  
Shama Milon, Cincinnati, OH  
Dilip Mohan Velu, MD, Bellerose, NY  
Aisha Mondal, MD, Charlottesville, VA  
Preska Melissa Moore, MD, Crozet, VA  
Julia Morrison, MD, Glen Oaks, NY  
Matthew William Morrison, MD, Tampa, FL  
Eric Morrow, MD, PhD, Providence, RI  
Kiran S. Munir, MD, Springfield, IL  
Trenton Myers, MD, Kansas City, MO  
Whitney Nall, MD, St. Louis, MO  
Sreenath Nekkalapu, MD, Keller, TX  
Jeannie Ngo, Omaha, NE  
Sahana Oley, MRCPSych, Manchester, ??  
William Oliva, MD, Oklahoma City, OK  
Carmen Orellana, MD, Springfield, IL  
Francine Ouellet, MD, MSc, FRCP, Québec, QC  
Xitaly Paniagua, MD, Alajuela, San Rafael, Costa Rica  
Srinivasa Chari Panuganti, MD, Hays, KS  
Philip Paparone, MD, Syracuse, NY  
Tapan Parikh, MD, MPH, Mays Landing, NJ  
Erik Paschall, MD, Los Angeles, CA  
Meenal Pathak, MD, Akron, OH  
Jennifer Patterson, MD, Charleston, SC  
Juan Pedraza, MD, Armonk, NY  
Anastasia Pemberton, MD, Houston, TX  
Ella Peresechenski, MD, Washington, DC  
Tolulope Peters, MD, Birmingham, AL  
Stacy-Ann Phillip, MD, Brooklyn, NY  
Michael Politis, MD, New York, NY  
Meriana Porras Marin, MD, Moravia, San José, Costa Rica  
Fanisah Porter, MD, Milwaukee, WI  
Robert Portley, MD, Dallas, TX  
Kimia Pourrezae, MD, Brooklyn, NY  
Srinath Prayaga, MD, Augusta, GA  
Natalie Prohaska, MD, Aurora, CO  
Matthew Prok, Denver, CO  
Tad Zhengzhang Pu, MD, Shanghai, Marilyn Pupo-Guillen, MD, Scottsdale, AZ  
Molly Reeves, MD, Birmingham, AL  
Mary-Catherine Rensko, DO, Honolulu, HI  
Sabrina Renteria, MD, Los Angeles, CA  
Shane David Riggs, MD, San Antonio, TX  
Zachary Robinson, MD, Denver, CO  
Christopher Rogers, MD, Westminster, CO  
Pharez Rolle, MD, Loma Linda, CA  
Kristin Rosseau, Philadelphia, PA  
Jennifer Ruane, MD, Philadelphia, PA  
Leigh J. Ruth, MD, Baltimore, MD  
Madhusmita Sahoo, MD, Voorhees, NJ  
Geetanjali Sahu, MD, Brooklyn, NY  
Thais Salan, MD, Sao Paulo, Brazil  
Luna Sanchez, MD, Durham, NC  
Adrienne Schlatter, Benicia, CA  
Sarah Schmitz, MD, Chapel Hill, NC  
Dr Liz Searle, MBBS, MRCPSych, London, UK  
Reena Shah, MD, Kansas City, KS  
Haider Shahid, MD, Tampa, FL  
Leilani Sharpe, MD, Los Angeles, CA  
Shad Shebak, MD, East Lansing, MI  
Alexander Sheppe, MD, New York, NY  
Suman Shiva, MD, Elmhurst, NY  
Larry Shores, MD, Colorado Springs, CO  
Joseph Shotwell, MD, Galveston, TX  
Vikas Sinha, MD, Brooklyn, NY  
Rangsun Sitthichai, MD, Watertown, MA  
Saurabh Somvanshi, MD, New York, NY  
Youueo Song, MD, Pittsburgh, PA  
Meredith Spada, MD, Pittsburgh, PA  
Kate J. Stanton, Worcester, MA  
Anderson Still, MD, Pittsburgh, PA  
Randy Su, DO, Cherry Hill, NJ  
Saravana T R Subbian, MRCPSych, Manchester, ??  
Anupama Sundar, MD, Valhalla, NY  
Ellen Takher, MD, Las Vegas, NV  
Timothy Tawa, MD, Cerritos, CA  
Sowmya Tewari, MD, New York, NY  
Maria Tocco, Royal Oak, MI  
Robert Toscano, MD, Richmond, VA  
Torey Troggio, MD, Los Angeles, CA  
Anh L. Truong, MD, Houston, TX  
Colby Tyson, MD, New York, NY  
Tom Vadakara, MD, Burr Ridge, IL  
Gaurav Vishnoi, MD, Brooklyn, NY  
Ankita Vora, MD, MPH, MS, St. Louis, MO  
Nasratullah Wahidi, MD, Lexington, KY  
Daniel Waldman, MD, New Orleans, LA  
Felicia Walker, MD, Durham, NC  
Hohui Wang, MD, San Diego, CA  
Michael Warden, DO, Rochester, MN  
Andrew Weller, MD, Merion Station, PA  
Nicholas Welsh, Chicago, IL  
Lilian White, Fairborn, OH  
Nolan Williams, MD, Albuquerque, NM  
John Wilson, III, MD, Brooklyn, NY  
Christine Wolfe, MD, Kaneohe, HI  
Adam Woods, MD, Cedar Rapids, IA  
Lavanya Wusirika, MD, Los Angeles, CA  
Tenzing Yangchen, MD, Stony Brook, NY  
Xiaoyi Yao, MD, New York, NY  
Margaret Yesalavage, DO, Philadelphia, PA  
Jillian Yoshimoto, DO, Honolulu, HI  
Cassidy Zanko, MD, Los Angeles, CA  
Jillian Yoshimoto, DO, Benicia, CA  
Jodi Zik, MD, Denver, CO
MAKE A DONATION. MAKE HOPE. MAKE AN IMPACT.

When you become an AACAP Hope Maker, you are making an important investment that gives children with mental illness an opportunity to heal.

You give them a life filled with more promise and hope, just as Dory inspires those around her with her song.

Fight children's mental illness all year long by becoming an AACAP Hope Maker.

Visit www.aacap.org/HopeMaker to get started today.

EMERGING RISKS REQUIRE ENHANCED COVERAGE

The comprehensive psychiatric malpractice insurance program from PRMS® has been enhanced to include at no additional cost:

- **MEDICAL LICENSE PROCEEDINGS** Separate limits up to $150,000
- **DATA BREACH** Separate limits up to $30,000
- **HIPAA VIOLATIONS** Separate limits up to $50,000

Child and Adolescent Psychiatrists Save 15%!

(800) 245-3333
PsychProgram.com/EnhancedPolicy
TheProgram@prms.com

Actual terms, coverages, conditions and exclusions may vary by state. Insurance coverage provided by Far American Insurance and Reinsurance Company (NAIC 35955), FARRCO is an authorized carrier in California. © number 3710-T, 3710-E, 3711-T, 3711-E. In California, claims Transferred to Professional Risk Management and Insurance Services.

Join the conversation & Stay informed...

@AACAP  /AACAP

AACAP NewsClips
- the latest and most relevant news articles on child psychiatry
- features AACAP members (that’s you!), their achievements, and involvements
- delivered to your inbox every M, W, & F

Email Stephanie Chow at schow@aacap.org to sign up!
Thank You for Supporting AACAP!

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

Gifts Received September 1, 2016 to October 31, 2016

$5,000 to $9,999
AACAP Norbert and Charlotte Rieger Award for Scientific Achievement
The Norbert and Charlotte Rieger Foundation
AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award
The Norbert and Charlotte Rieger Foundation
AACAP Norbert and Charlotte Rieger Service Program Award for Excellence
The Norbert and Charlotte Rieger Foundation

$1,000 to $4,999
Break the Cycle
Michael and Julie Houston/ Chilton, in honor of Andrés Martin, MD, MPH

Campaign for America’s Kids
Gabrielle L. Shapiro, MD
Ülkü Ülgür, MD, International Scholar Award
Abel Merril, Esq

Where Most Needed
General Contribution
G. Davis Gammon, MD
Adele L. Martel, MD, PhD

$500 to $999
Life Members Fund
Lawrence Brain, MD
Fred Seligman, MD
Virginia Q. Anthony Fund
Fred Seligman, MD
Where Most Needed
General Contribution
Jennifer R. Robinson, PharmD*

$100 to $499
Break the Cycle
Cathryn Galanter, MD
Douglas A. Kramer, MD, MS
Yiu Kee Warren Ng, MD

Campaign for America’s Kids
Martin J. Drell, MD
John Leikaff, MD
D. Richard Martini, MD
Adrian Sondheimer

E. James Anthony Fund
Wun Jun Kim, MD, MPH

Life Members Fund
Perry B. Bach, MD
Wun Jung Kim, MD, MPH
William M. Klykylo, MD
Peter Metz, MD
Theodore Petti, MD
Alan P. Sandler, MD
William J. Swift, MD

Paramjit T. Joshi International Scholar Award Fund
Wun Jun Kim, MD, MPH

Where Most Needed
General Contribution
Robert G. Bleck, MD
Matthew N. Koury, MD, MPH♥
Victoria Winkeller, MD*

Up to $99
Campaign for America’s Kids
Douglas W. Adams, MD*
Chandramouleswa Rao Amara, MD
Brent R. Anderson, MD
Shlomi Antebi*
Marie E. Armentano, MD
William Arroyo, MD
Kathleen Banks, MD*
Elin Barth-Berg, MD
James E. Bedford, MD
B. James Bennett, MD
Chester M. Bershling, MD
Nancy B. Black, MD
Miguel Angelo Boarati, MD
Melanie J. Brace, MD
Thomas Bruggger, MD
Bryan Bruns, MD*
Frances Burger, MD
Pamela Campbell, MD
Amelia Marie Campos, MD*
Kathy Carney, MD*
Gloria M. Carrera, MD
Douglas Chavis, MD*
Louis E. Costello, MD
Richard Cruz, MD
David R. Danly, MD*
Nancy L. Debink* 
James Demer, MD
Seth Dewey, MD*
Calos Diogo, MD*
Frank R. Drake, MD
Shashi K. Elangovan, MD*
Mario A. Ercole, MD*
Spencer Eth, MD*
Joshua D. Feder, MD
Daniel J. Feeney, MD*
Robia A. Fields, MD
Elizabeth A. Finley-Belgrad, MD
Peggy M. Forbes, MD
Sarah Fox, MD
Kory A. Frey, MD*
Susan Friedman, MD
Joel Goldstein, MD*
Ellen Grosh, MD*
Daniel E. Grosz, MD*
Dennis C. Grygotis, MD
Lora Gunn, MD*
Anne Gurian, MD*
Carol R. Harrus, MD
Jabeen Hayat, MD
Elizabeth Hedden, MD*
Linda Hryhorczuk, MD*
Luis Isaza, MD*
Bernard Jacobs, MD*
David A. Jeffery, MD*
Michael Jellinek, MD
Kyle S. John, MD
Clarice J. Kestenbaum, MD
Virginia M. Khoury, MD
Frank H. Kirchner, MD*
Gary Klein, MD
John N. Korger, MD*
Debra E. Koss, MD
Elise Kressley, MD
David A. Krulee, MD
Bernard Kumetat, MD*
William LeBoeuf, MD
Stacy Leon, MD*
Owen W. Lewis, MD
Jeffrey London, MD
Bernard R. Lopez, MD*
Cathy Lore, MD
James J. Maynard, MD
John T. McCarthy, MD
Robert S. McConaughy, MD
Jennifer L. Mogul, MD
Donald Monette*
Louis H. Monty, MD
Richard Morse, MD
Saran Mudumbi, MD
Anna E. Mueling, MD
Jeffrey A. Naser, MD*
Elisa Newman, MD
Maria Oliveira, MD
Eileen Pagano, MD*
Varsha Patel, MD*
Carolanne K. Phelan, MD
Kevin V. Quinn, MD
George Realmuto, MD
Maryam Rezai, MD*
Mark Riddle, MD
Jonathan B. Roth, MD*
Leila Sadeghi, MD*
Rupa Shetty, MD
Rebecca Siegel, MD*
Janice Singerman, MD
Howel W. Slaughter, MD*
Paula Marie Smith, MD♥
Patrick G. Sola*
Suzanne Starkey, MD*
Colin Stewart, MD
Joan Sturgis, MD
Sady Sultan, MD
Elizabeth R. Sunde, MD
Hamid Tabatabai, MD
Marshall L. Teitelbaum, MD*
Dejuan Thomas-Singletary, MD
Ronald C. Thuron, MD
Herman Tolbert, MD
Gargi Trivedi, MD*
Stanley Turecki, MD
Alexandru L. Vasile, MD
Raquel Vasquez, MD*
Jorge J. Villalba, MD*
Nina Wang-Helmer
Chandra Weerasinghe, MD*
Meredith Weiss, MD
Preston Wiles, MD*
Edwin Williamson, MD*
Thomas Wright, MD*

**Life Members Fund**
Steven P. Cuffe, MD
Alan Ezagui, MHCA♥
Boris Rubinstein, MD

**Virginia Q. Anthony Fund**
Alice R. Mao, MD♥

**Where Most Needed**
*General Contribution*
Stephen J. Cozza, MD♥
Ryan Herringa, MD, PhD♥
Mini Tandon, DO♥
Laine E. Taylor, DO

**1953 Society Members**
Anonymous (5)
Steve and Babette Cuffe

* Indicates a first-time donor to AACAP
♥ Indicates a Hope Maker recurring monthly donation

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

All AACAP Members are encouraged to submit articles and news items for publication, as well as photographs, poems, cartoons, and drawings.

Categories for submission and consideration are:

- **Letters to the Editor**, of 250 words or less, submitted in response to an article published in the AACAP News should be submitted directly to the Editor at urao@mmc.edu or through the National Office to Managing Editor Rob Grant at rgrant@aacap.org. Please include your name and contact information.

- **Photographs** to be published on the front page, inside standing alone, or accompanying relevant articles or stories. Photographs should—in an artistic way—illustrate themes pertaining to children, childhood, parents, and children, parenting, or families. Members are invited to submit up to two photographs every two months for consideration. Please send a high-resolution version to the AACAP News photo editor at ARosen45@aol.com along with a description of 50 words or less.

- **Opinion pieces**, including debates, 800-1500 words

- **Articles** approved by and coming from Committees, 600-1200 words

- For a list of column coordinators for Diversity and Culture, Forensics, Ethics, Clinical Vignettes, and Youth Culture email pjutz@aacap.org.

- **Newsworthy items**
  - Fully developed News Articles, 800-1500 words
  - Kudos, highlighting member achievements 250 words or less
  - Regional Organization of Child and Adolescent Psychiatry, 250 words or less
  - Committee activity reports or updates, 250 words or less

- **Features**, 600-1200 words
  - Interviews
  - Discussions of movies or literature
  - Creative Arts, e.g. poems, cartoons, drawings (limited to 1 page)
A national initiative to improve the lives of children with mental illnesses

Did You Know?
Since 2008, CFAK has:

1. Invested nearly $1.1M in AACAP fellowships, travel awards, and research

2. Impacted the careers of more than 190 medical students, residents, and junior scholars

3. Approved 72% of all funds requested

Your contribution funded my research at the Seaver Autism Center, where I have found a new passion for the field of child psychiatry.

Justin Key
Summer Medical Student Fellowship, 2014

The AACAP Pilot Research Award ... has made an important impact on the trajectory of my research career, and I so greatly appreciate your generous support.

Stephanie Ameis, MD
Pilot Research Grantee, 2015

I really appreciate the mentorship opportunities [at the Annual Meeting]. It taught me things I brought directly back to use clinically in my work. ... I will be an AACAP member for life.

Elizabeth Brannan
Educational Outreach Program Recipient, 2014
AACAP Award Opportunities
FOR MEDICAL STUDENTS, RESIDENTS, AND EARLY CAREER PSYCHIATRISTS

RESIDENTS AND JUNIOR FACULTY

AACAP Pilot Awards
Application Deadline: March 30, 2017
Provides $15,000 to members with a career interest in child and adolescent mental health research
- Research Award for Child and Adolescent Psychiatry Residents and Junior Faculty, Supported by AACAP
- Research Award for Child Psychiatry Residents and Junior Faculty focusing on Attention Disorders and/or Learning Disabilities, Supported by AACAP's Elaine Schlosser Lewis Fund
- Research Award for General Psychiatry Residents, Supported by Pfizer and Arbor Pharmaceuticals

AACAP Educational Outreach Programs (EOP)
Application Deadline: June 30, 2017
Provides the opportunity for residents to travel to AACAP’s Annual Meeting
- EOP for Child and Adolescent Psychiatry Residents, Supported by the AACAP Endowment, AACAP’s John E. Schowalter, MD, Endowment Fund, and AACAP’s Life Members Fund
- EOP for General Psychiatry Residents, Supported by the AACAP Endowment

AACAP Systems of Care Special Program Clinical Projects Scholarship,
Co-sponsored by SAMHSA's Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee
Application Deadline: July 13, 2017
Provides support of $750 to attend AACAP’s Annual Meeting and present a poster on a systems-of-care-related topic

Junior Investigator Award, Supported by AACAP’s Research Initiative
Application Deadline: March 17, 2017
Provides $30,000 a year for two years for one child and adolescent psychiatry junior faculty

RESIDENTS

JUNIOR FACULTY

MEDICAL STUDENTS

Medical Student Fellowships
Application Deadline: February 17, 2017
Provides a $3,500 to $4,000 stipend for 12 weeks of research training and covers travel expenses for AACAP’s Annual Meeting
- Jeanne Spurlock Minority Medical Student Research Fellowships in Substance Abuse and Addiction, Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK)
- Summer Medical Student Fellowship Program, Supported by CFAQ Life Members Mentorship Grants for Medical Students
Application Deadline: July 13, 2017
Provides a travel grant of $1,000 for medical students to travel to AACAP’s Annual Meeting and network with leaders in the field

*All awards contingent upon available funding.

For more information, visit www.aacap.org/awards.
AACAP Distinguished Member Award Opportunities

**Application Deadline: May 2, 2017**

**AACAP Cancro Academic Leadership Award** recognizes a currently serving General Psychiatry Training Director, Medical School Dean, CEO of a Training Institution, Chair of a Department of Pediatrics, or Chair of a Department of Psychiatry for his or her contributions to the promotion of child and adolescent psychiatry.

**AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities** recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with intellectual and developmental disabilities.

**AACAP Irving Philips Award for Prevention** 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.

**AACAP Jeanne Spurlock Lecture and Award on Diversity and Culture** recognizes individuals who have made outstanding contributions to the advancement of the understanding of diversity and culture in children’s mental health, and who contribute to the recruitment into child and adolescent psychiatry from all cultures.

**AACAP Norbert and Charlotte Rieger Service Program Award for Excellence** recognizes innovative programs led by AACAP members that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community.

**AACAP Sidney Berman Award for the School-Based Study and Treatment for Learning Disorders and Mental Illness** 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.

**AACAP Simon Wile Leadership in Consultation Award**, supported by the Child Psychiatry Service at Massachusetts General Hospital, acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry.

**Academic Paper Awards
Application Deadline: May 2, 2017**

**AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award** recognizes the best published or unpublished paper written by an AACAP member using a psychodynamic psychotherapy framework.

**AACAP Robinson-Cunningham Award** recognizes the best manuscript written by a resident during child and adolescent psychiatry training.

**International Scholar Award Opportunities
Application Deadline: July 13, 2017**

**AACAP Paramjit Toor Joshi, MD, International Scholar Awards** recognize mid-career international physicians who primarily work with children and adolescents providing mental health services outside the United States.

**AACAP Ülkü Ulgür, MD, International Scholar Award** recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

For details about all awards, eligibility requirements, and for access to applications and nomination information, visit [www.aacap.org/awards](http://www.aacap.org/awards).
POLICY STATEMENTS

Policy Statement Procedures

» Once a final draft policy statement is submitted by an individual author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Group (PSAG) via the National Office, the Policy Statement Advisory Group Chair directs that:
  • the author(s) is told what major revisions or minor edits are necessary. After the author(s) has revised the statement, they may resubmit to the PSAG;
  OR
  • The author(s) is informed that the statement does not meet the criteria for a policy statement.

» If the PSAG recommends it, the Executive Committee reviews the statement to decide whether it should be e-mailed to Council or placed on Council’s meeting agenda. If the Executive Committee decides not to advance the statement, the author(s) may be contacted to resolve the issue(s).

» If emailed, Council members have a two-week discussion period in which to convey concerns and ask questions. After this period, a one-week voting period begins.

» If Council approves the statement, the author(s) is notified. The statement is printed in *AACAP News* and distributed to the recommended sources then placed on the AACAP website.

» If Council does not approve the statement, the author(s) may be requested to rewrite and resubmit to the PSAG with an explanation of what changed.

» Every two years, the PSAG reviews all policy statements for necessary revisions or updates. Revisions are made by the original author(s), if available, or by known specialists in that area of expertise. The revising author(s) is given a 3-month period to make changes and resubmit to the PSAG for final approval.

» Annually, committee chairs are asked to review policy statements online and update if necessary.


AACAP Policy Statement Requirements

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

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

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

AACAP Resource Centers

AACAP Resource Centers contain consumer-friendly definitions, answers to FAQ, clinical resources, expert videos, and abstracts from JAACAP, Scientific Proceedings, and relevant Facts for Families.

Visit www.aacap.org to harness the power of our resources today!

TOP 5

1. Oppositional Defiant Disorder
2. ADHD
3. Anxiety Disorders
4. Depression
5. Bipolar Disorder

There’s strength in numbers, so share what you know!
CLASSIFIEDS

ILLINOIS

FACULTY CHILD AND ADOLESCENT PSYCHIATRISTS
Chicago, IL

The Northwestern University Feinberg School of Medicine and the Ann and Robert H. Lurie Children’s Hospital of Chicago are seeking two child psychiatrists to join a vibrant multidisciplinary child psychiatry department in a nationally ranked freestanding children’s hospital located on the medical school campus.

One position has primarily outpatient and teaching duties. The other position combines outpatient and consultation/liaison-emergency psychiatry clinical care and teaching. C/L and ED clinical experience (especially pediatric hospital-based) and ABPN certification (or eligibility) in child and adolescent psychiatry required. Fluency in Spanish would be a plus. For the C/L position, training in Pediatrics is desirable. Instructor or Assistant Professor position is full-time continuing appointment faculty, requiring experience and excellence in teaching and an interest in an academic environment.

Rank and salary commensurate with qualifications and experience. Research pilot funding is available. Hiring is contingent upon eligibility to work in the United States and licensure in Illinois. Start date negotiable, as soon as possible after licensure in Illinois and Lurie Children’s medical staff membership. Applications will be evaluated as received. Positions will remain open until filled. Send CV with a letter describing clinical and academic interests to: Mina Dulcan, MD, Head, Lurie Children’s Department of Psychiatry, E-mail: mdulcan@luriechildrens.org

Northwestern University and the Lurie Children’s Medical Group are Equal Opportunity, Affirmative Action Employers of all protected classes, including veterans and individuals with disabilities. Women, underrepresented racial and ethnic minorities, individuals with disabilities, and veterans are encouraged to apply. Hiring is contingent upon eligibility to work in the United States.

FACULTY CHILD AND ADOLESCENT PSYCHIATRIST
Department of Psychiatry and Behavioral Sciences
Northwestern University/Feinberg School of Medicine
Chicago, IL

The Northwestern University Feinberg School of Medicine and the Ann and Robert H. Lurie Children’s Hospital of Chicago are seeking a medical director of our established, successful Psychiatry and Behavioral Health Consultation Service in a vibrant multidisciplinary child psychiatry department in a nationally ranked freestanding children’s hospital located on the medical school campus.

The position combines outpatient and consultation/liaison-emergency psychiatry clinical care and teaching. C/L and ED clinical experience (especially pediatric hospital-based) and ABPN certification in child and adolescent psychiatry required. Fluency in Spanish would be a plus and training in Pediatrics is desirable. Assistant or Associate Professor position is full-time continuing appointment faculty, requiring experience and excellence in teaching and an interest in an academic environment.

Rank and salary commensurate with qualifications and experience. Research pilot funding is available. Hiring is contingent upon eligibility to work in the United States and licensure in Illinois. Start date negotiable, as soon as possible after licensure in Illinois and Lurie Children’s medical staff membership. Applications will be evaluated as received. Position will remain open until filled. Send CV with a letter describing clinical and academic interests to: Mina Dulcan, MD, Head, Lurie Children’s Department of Psychiatry, E-mail: mdulcan@luriechildrens.org

Northwestern University and the Lurie Children’s Medical Group are Equal Opportunity, Affirmative Action Employers of all protected classes, including veterans and individuals with disabilities. Women, underrepresented racial and ethnic minorities, individuals with disabilities, and veterans are encouraged to apply. Hiring is contingent upon eligibility to work in the United States.

LOUISIANA

CHILD AND ADOLESCENT PSYCHIATRIST
New Orleans, LA

Ochsner Health System is seeking a BC/BE Child and Adolescent Psychiatrist to practice at Ochsner Medical Center in New Orleans. Opportunities exist for teaching through our combined Ochsner-LSU psychiatry residency program. Salary offered will be competitive and commensurate with experience and training. Our Child and Adolescent Psychiatry Section offers outpatient consultation, evaluation, testing and treatment for children and adolescents with problems related to behavior, feelings, emotions, thinking and learning. The approach involves teams of social workers, psychologists and psychiatrists, in close collaboration with educational specialists, primary care pediatricians and pediatric specialists. Ochsner Health System is Louisiana’s largest non-profit, academic, healthcare system with 28 owned, managed and affiliated hospitals and more than 60 health centers. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a “Best Hospital” across three specialty categories caring for patients from all 50 states and more than 80 countries worldwide each year. Ochsner employs more than 1,000 physicians in over 90 medical specialties and subspecialties and conducts more than 1,000 clinical research studies. For more information, please visit www.ochsner.org and follow us on Twitter and Facebook. Ochsner Health System and The University of Queensland
Medical School in Brisbane, Australia began a unique, joint partnership in 2009 by opening the University of Queensland School of Medicine Clinical School at Ochsner, providing U.S. medical students with an unprecedented educational experience. New Orleans is one of the most exciting and vibrant cities in America. Amenities include multiple universities, academic centers, professional sports teams, world-class dining, cultural interests, renowned live entertainment and music. Please e-mail CV to profrecruiting@ochsner.org or call 800-488-2240 for more information. Reference # CAPSYC-5. Sorry, no opportunities for J1 applications. Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.

Company: Ochsner Health System (966158)
Job ID: 8377627
http://jobsource.aacap.org/jobs/8377627

MINNESOTA
CHILD AND ADOLESCENT PSYCHIATRIST

Children's Hospitals and Clinics of Minnesota is a not-for-profit, comprehensive health care provider serving the diverse needs of children from infancy through adolescence. With 316 beds we are the sixth largest children's healthcare organization in the US. This full time position will include approximately half time consultation/liaison and half time outpatient child and adolescent psychiatry. Primary responsibilities include leading a consultation team to provide consultative services to pediatric providers throughout Children's inpatient and outpatient services. The consultation/liaison service will be a new program and the outpatient service will be an expansion to a new campus so the opportunity to help develop these programs is available.

Job Requirements:
Licensed to practice medicine in Minnesota. Board certified, or board eligible in Child and Adolescent Psychiatry from the American Board of Psychiatry and Neurology. Strong clinical skills with at least 2 years of experience in treating children and adolescents, including diagnostic assessment, treatment planning, and medication management. Ability to work independently, take initiative and make decisions based on sound judgment. Evidence of strong clinical skills with at least 2 years of experience in treating children and adolescents. Experience with Consultation Liaison child psychiatry and good communication skills with pediatricians. Demonstrated ability to collaborate, coordinate and consult with other clinicians, including physicians, social workers, and psychologists. If interested, please submit a cover letter and CV to Ryan Berreth at Ryan.Berreth@childrensmn.org.

Company: Children's Hospitals and Clinics of Minnesota (943330)
Job ID: 8465204
http://jobsource.aacap.org/jobs/846520

MISSOURI
CHILD AND ADOLESCENT PSYCHIATRIST

St. Louis, MO

Come grow with Mercy Kids. Child and Adolescent Psychiatrist Position in St. Louis, MO, Mercy Clinic is seeking a full-time BC/BE Child and Adolescent Psychiatrist to join a practice with five Board-Certified Child and Adolescent Psychiatrists delivering inpatient and outpatient services. About Mercy Children's Hospital: Largest child and adolescent psychiatry group in Missouri. A 13-bed inpatient behavioral health unit designed to provide a healing, kid-friendly environment. 24-hour in-house pediatric hospitalist coverage. 175 pediatric providers on staff with over 80 fellowship-trained pediatric specialists. Educational program for University of Missouri medical students. Member of Children's Hospital Association. System-wide EPIC EMR. This Opportunity Includes: Highly competitive income guarantee with room to grow based on production. Comprehensive benefits, including health, dental, vacation and CME. Relocation assistance and professional liability coverage. Mercy Hospital is located in suburban St. Louis, which offers beautiful residential areas with a remarkably low cost of living for all the comforts and attractions it affords. The four-season climate, five-star restaurants and major league sporting attractions make St. Louis an attractive place to live, work and play! For more information, please contact: Lisa Hauck, MBA, Senior Physician Recruiter, 314-364-3840, fax: 314-364-2597, lisa.hauck@mercy.net, mercy.net.

EOE/AA/Minorities/Females/Disabled/Veterans Employer

Company: Mercy (883968)
Job ID: 8394969
http://jobsource.aacap.org/jobs/8394969

NEW JERSEY

CHILD AND ADOLESCENT PSYCHIATRY POSITIONS WITH RWJBARNABAS HEALTH (OUTPATIENT AND TELEPSYCH)

RWJBarnabas Health is Seeking Child and Adolescent Psychiatrist for Outpatient and Telepsych Positions in New Jersey RWJBarnabas is seeking board-certified Child and Adolescent psychiatrists for both outpatient and telepsychiatry positions within the RWJBarnabas Health Behavioral Health Network. Outpatient positions include locations in northern New Jersey (Newark) and the Jersey Shore (Long Branch). As the largest behavioral health network and the largest integrated health system in NJ, RWJBarnabas Health offers competitive compensation to physicians with strong base salary plus additional compensation for call AND quality-based bonus incentives. RWJBarnabas Health psychiatrists also receive a robust benefits package including: Health insurance Malpractice (with tail) 401k with company match 5 days off for CME Budget for CME 31 Paid Time Off (PTO days) Budget for licensing, books, continued on page 308
association fees, etc. We welcome both 2017 fellows and experienced physicians to apply! Already employed? You may want to consider Per Diem Psychiatry positions or call coverage to earn additional income! For information or to apply for these or additional opportunities with RWJ Barnabas Health, please contact Annelise Catanzaro, Manager of Physician Development at (973) 322-4364 or by e-mail: annelise.catanzaro@gmail.com.

Job Requirements:
Candidates must be: Board-Certified in General, Geriatric and/or Child/Adolescent Psychiatry Licensed or eligible for licensure in New Jersey

Company: Barnabas Health (886156)
Job ID: 8459191
http://jobsource.aacap.org/jobs/8459191

NEW YORK

BC/BE CHILD AND ADOLESCENT PSYCHIATRIST/GENERAL PSYCHIATRIST WITH ADOLESCENT PSYCHIATRY EXPERIENCE

If you are a BC/BE Child and Adolescent psychiatrist, or a General Psychiatrist with experience treating adolescents, who would enjoy growing in a flourishing multidisciplinary fee for service practice not dependant on managed care, we have a part-time position open (with potential to be full-time). Psychiatric evaluations, medication management, and psychotherapy if interested. Possible clinical research opportunities. The practice has a full time office staff responsible for making appointments, taking messages and collecting fees. There is an integrated Electronic Medical Record system with e-prescribing that can conveniently be accessed remotely. Be part of a team that provides quality services for an affluent suburban community thirty miles from New York City. Benefit package available.

Job Requirements:
BC/BE in Child and Adolescent Psychiatry or General Psychiatry with experience treating adolescents. CAP fellows in their last year of training considered General Psychiatry residents in their 4th year of training considered.

Company: Barnabas Health (886156)
Job ID: 8459191
http://jobsource.aacap.org/jobs/8459191
an occupational therapist and a speech therapist. Because our practice is 85% Medicaid, most of our families are struggling. We are looking for someone with a keen interest in being creative, working as part of a passionate team and serving children in need. Please see the workplace description.

**Job Requirements:**
Prescribe, direct, or administer psychotherapeutic treatments and/or medications to treat mental, emotional, or behavioral disorders in children 19 and under. Treat psychiatric conditions in teens and young children using a conservative approach, which should include CBT. Prescribe medication on a conservative basis to treat verifiable mental health diseases and conditions. Analyze quantitative data to determine effectiveness of treatments or therapies. Explain treatment plans to patients and their parents or guardians and provide familial support throughout treatment program. Demonstrable ability to connect with and provide support for children Gather and maintain patient information and records, including social or medical history obtained from patients, relatives, or other professionals. Record patient medical histories. Keep adequate ongoing documentation on treatment. Feel comfortable using an EMR/EHR system for documentation (we use Practice Fusion). Analyze and evaluate patient data or test findings to diagnose nature or extent of mental disorder. Examine or conduct laboratory or diagnostic tests on patients to provide information on general physical condition or mental disorder. Explain medical procedures or test results to patients or family members. Examine patients to assess general physical condition and for diagnostic purposes. Counsel patients during office visits. Advise or inform guardians, relatives, or significant others of patients’ conditions or treatment. Collaborate with physicians, psychologists, social workers, psychiatric nurses, or other professionals to discuss treatment plans and progress as appropriate. Take continuing education classes, attend conferences or seminars, or conduct research and publish findings to increase understanding of mental, emotional, or behavioral states or disorders. Maintain and continually update medical or professional knowledge. Unrestricted state license to practice medicine required. Current DEA permit required. Willingness to learn and follow clinic’s standards of practice including being part of a child’s medical home.

**Company:** Kids Count Pediatrics, PLLC (1005607)
**Job ID:** 8557406
http://jobsource.aacap.org/jobs/8557406

**Pennsylvania**

**Child and Adolescent Opportunity**

**York, PA**

Child and Adolescent Psychiatrist Take Advantage of Our Educational Loan Repayment Plan! WellsSpan Health, a progressive medical community in York, PA, is seeking a successful candidate who will provide Child and Adolescent outpatient behavior health care. This is an opportunity to join a large Behavioral Health department with strong support from leadership. WellsSpan Health is a top-rated, integrated health system with a focus on a high-quality patient care. About the Practice Join a team of 6 fellowship-trained child and adolescent psychiatrists Excellent daily schedule with no weekend appointments Typically manage 15 patients per shift Call is limited to the practice Must have PA medical license and be a BC/BE Psychiatrist Must be a graduate of accredited school of medicine with Doctor of Medicine degree plus completion of residency training program in Psychiatry Be a member of our large Behavioral Health Department with over 75 Psychiatrists and 60 licensed therapists Benefits $235,000 guaranteed salary, $25,000 sign on bonus and $80,000 educational loan repayment Health, life and disability insurance Retirement savings plan with employer automatic contribution and employer match Medical malpractice insurance and tail coverage Continuing Medical Education time off and stipend Relocation Physician-led medical group Lifestyle Conveniently located 45 minutes north of Baltimore and 90 minutes west of Philadelphia Abundant outdoor and cultural activities including restaurants, theatre, golf courses, hiking, water sports, farmers markets and downtown access to a 42-mile recreation trail Family oriented community, with excellent schools, low cost of living and low crime rates

**Job Requirements:**
Successful completion of an ACGME accredited psychiatry residency Successful completion of an ACGME accredited child and adolescent fellowship Eligibility to obtain a PA medical license Eligibility to obtain a DEA license.

**Company:** WellSpan Health (894076)
**Job ID:** 8479328
http://jobsource.aacap.org/jobs/8479328

**Developmental Disabilities Fellowship**

**Lancaster, PA**

WellSpan Health Philhaven Center for Autism and Developmental Disabilities (CADD)

Philhaven, the region's most comprehensive system of behavioral health services in central Pennsylvania, is now affiliated with WellSpan Health, the largest nonprofit healthcare system in the region. This is an opportunity to join a top-rated integrated health system with a focus on high quality, patient-centered care that is committed to addressing the needs of vulnerable populations.

WellSpan has created a one-year fellowship experience for individuals interested in developing expertise in the care of children, adolescents and adults with developmental disorders such as autism and intellectual disabilities.

- Learn the skills necessary to be a psychiatric leader in this rapidly changing field.
- Spend the year embedded in the rich learning environment of CADD’s multidisciplinary team.
- Learn how to incorporate applied behavior analysis in your psychiatric practice.

[continued on page 310]
Classifieds continued from page 309

- Broaden your expertise with rotations in pediatric neurology, genetics and primary care consultation.

Join the CADD team in developing a new model of lifelong care for those with autism and intellectual disabilities and their families.

This fellowship is open to individuals who will have completed residencies in both general psychiatry and child and adolescent psychiatry by June 2017.

Contact:
Vicki R. Daniel, MBA
Director of Operations, CADD
1886 Rohrerstown Road
Lancaster, PA 17601
(717)735-1920 x6012
vdaniel2@wellspan.org

RHODE ISLAND

ATTENDING CHILD AND ADOLESCENT PSYCHIATRIST – HASBRO PEDIATRIC MEDICAL PSYCHIATRIC INTEGRATED CARE I
Providence, RI

As a rapidly growing center of integrated care for pediatic patients, the Hasbro Children’s Hospital, in conjunction with Bradley Hospital, is seeking a child and adolescent psychiatrist for a full-time attending position in the Pediatric Medical Psychiatric Integrated Care Inpatient Program. The program is an integrated care inpatient medical/psychiatric unit serving patients 6-18 years old with pediatric medical illnesses including but not limited to eating disorders, somatoform disorders, pain syndromes, and chronic illness non-adherence. The multidisciplinary team includes psychiatry, pediatrics, psychology, social work, milieu therapy, nursing, child life, and involvement of pediatric specialty services as needed. The attending psychiatrist is responsible for oversight and coordination of medical and psychological treatment planning as well as psychiatric medication management for assigned patients. He/she collaborates with attending pediatrics providers and pediatric therapists and integrates the clinical activities of the multidisciplinary team with respect to the treatment of his/her patients. The unit provides a vibrant clinical, academic and research environment as well as a training site for the Child and Adolescent fellowship, the Triple Board residency, the psychiatry residency, and the pediatric residency. The psychiatrist is responsible for the supervision of trainees providing services to his/her patients. Please send a CV along with a letter of interest to Daniel Spencer, MD, Medical Director, Hasbro Inpatient Med/Psych Unit, Hasbro Children’s Hospital, 593 Eddy Street, Providence, RI 02903 and/or e-mail: dspencer@lifespan.org.

Job Requirements:
Qualifications include Board Certification/Board Eligibility in Child and Adolescent Psychiatry, licensing or license-eligibility in Rhode Island, strong clinical skills, and the ability to work in an interdisciplinary team. This is a full time position with shared call responsibility. Salary and benefits are competitive and commensurate with level of training and experience. The successful applicant will be eligible for an academic appointment at the appropriate level in the Alpert Medical School of Brown University. Bradley Hospital is an Equal Employment Opportunity employer.

Company: Bradley Hospital/Lifespan Physicians Group (997148)
Job ID: 8471402
http://jobsource.aacap.org/jobs/8471402

DIRECTOR, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY VICE CHAIR, DEPARTMENT OF PSYCHIATRY AND HUMAN BEHAVIOR
Providence, RI

Lifespan and Hasbro/E. P. Bradley Hospitals and the Department of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University, Providence, RI, are seeking a full time Psychiatrist for Director, Division of Child and Adolescent Psychiatry and Vice Chair. The successful candidate must qualify for a full-time medical faculty academic appointment at the rank of Professor or Associate Professor, Research Scholar Track in the Department of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University. Minimum requirements include: Doctor of Medicine Degree certified in Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology; eligible for Rhode Island Medical License; and have a distinguished national reputation for academic accomplishment in research, scholarship and teaching. Lifespan is an EEO/AA employer and encourages applications from minorities and women. Review of applicants will begin immediately and will continue until the position is filled or the search is closed. Please apply online at https://apply.interfolio.com/38187.
The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

The new JobSource is simple and easier to use. Get to everything you need with just a few clicks. Visit us online at www.aacap.org and find JobSource under Quick Links or Member Resources.

With questions, please contact Samantha Phillips, Membership & Communications Coordinator, at sphillips@aacap.org.
ADVERTISING RATES

Inside front, inside back or back cover . . . $4,000
Full Page . . . . . . . . . . . . . . . . . . . . . . . . . . . $2,000
Half Page . . . . . . . . . . . . . . . . . . . . . . . . . . . $1,600
Third Page . . . . . . . . . . . . . . . . . . . . . . . . . . . $1,100
Quarter Page . . . . . . . . . . . . . . . . . . . . . . . . . . . $700

CLASSIFIED ADVERTISING RATES

- $350 for 100 words
- $375 for 150 words
- $400 for 200 words
- $425 for 250 words
- $450 for 300 words

- Classified ad format listed by state. Typesetting by AACAP.
- Commission for advertising agencies not included.

ADVERTISING DEADLINES

January/February 2017 . . . . . . . . . . . November 27
March/April 2017 . . . . . . . . . . . . . . . . . . January 27
May/June 2017 . . . . . . . . . . . . . . . . . . . . March 27
July/August 2017 . . . . . . . . . . . . . . . . . . . . May 27
September/October 2017 . . . . . . . . . . . July 27

DISCOUNTS

- AACAP members and nonprofit entities receive a 15% discount.
- Advertisers who run ads three issues in a row receive a 5% discount.
- Advertisers who run ads six issues in a row receive a 10% discount.

For any/all questions regarding advertising in AACAP News, contact communications@aacap.org.