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Cover Photo: 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
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.

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

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Common Sense Gun Control

Personally, as a lifelong bird hunter and owner of a number of well-worn shotguns, I strongly support gun registration, waiting periods, restrictions on assault weapons and access to firearms by youth, background checks, and strict enforcement of existing laws pertaining to firearms—all of which are spelled out clearly in our policy statement. Also explicitly supported are the freedom and funding for research on gun safety, gun violence, and its traumatic impact on children. Our policy statement also encourages bringing an end to placing restrictions on the questions physicians can ask about access to firearms in the home. I am particularly proud to be involved with AACAP when we stand up publicly and clearly for what we believe is the right position on such an important issue.

Our approach to public policy is not the only AACAP activity that makes my heart beat faster; the promise of the upcoming Annual Meeting in New York is really exciting. We are anticipating the biggest AACAP meeting ever, due to the irresistible combination of cutting-edge programs and the charms of the Big Apple.

Furthermore, I will be able to share my Presidential Initiative on Integrated Care with you in many venues throughout the week. I would especially like to highlight AACAP’s Karl Menninger, MD, Plenary: A Common Struggle: A Personal Journey Through the Past and Future of Mental Illness and Addiction on Wednesday, October 28 from 9:00-9:45 am. I am thrilled to be chairing this event, which features The Honorable Patrick J. Kennedy as the speaker. I invite you to attend this sure-to-be stimulating event, as well as the many other programs that will discuss the future of integrated care in our specialty.

Looking forward to seeing you all there!

Gregory K. Fritz, MD
President, AACAP
Integrated Care for Seriously Ill Children: The Synergy of Psychosomotics and Palliative Care

While there is increasing interest in the many possibilities for integrating psychiatry into primary and sub-specialty clinics, another area that is ripe for integration is between consultative and liaison teams. Amongst these, few greater opportunities exist for high-level expertise mergers than between psychosomatic and palliative care clinicians (Irwin and Ferris 2008).

The med-psych interface of working with seriously ill children is the bedrock of psychosomatics. Likewise, palliative care exclusively deals with the quality of life of patients with life-limiting illness and complex chronic conditions. Psychosomatic and palliative care clinicians both consult and liaison with subspecialty pediatric teams in inpatient and outpatient settings. Despite these similarities, there are important barriers and differences that exist.

Pediatric palliative care is a young field still finding itself. Like pediatric psychosomatics, it is frequently battling with insurers and managed care for adequate reimbursement, often relying on charitable donations and medical teams buying out its time for solvency. Pediatric palliative care similarly suffers from substantial need, with more vacant positions than appropriately trained clinicians. Lastly, pediatric palliative care is regularly misunderstood as an end of life and hospice-only field, with many clinicians and families confused by their involvement in non-terminal suffering.

What Psychiatry Can Offer Pediatric Palliative Care

Our palliative care colleagues are some of the most consistently eager early-adopters of psychiatric knowledge. They pride themselves on learning and mastering vast arrays of symptom management. Palliative care teams are often comprised of pediatricians, nurse practitioners, social workers, and sometimes chaplains, art therapists, child life specialists, and/or psychologists. Their teams work in multiple settings far and wide, doing home visits, working with hospices, and consulting in clinics and ICUs. To this end, they desire and are required to be knowledgeable in mental health for comprehensive care as well as their board exams.

Some clinicians might view palliative care physicians as “gung-ho” and “cavalier,” practicing mental health without having gone through a psychiatric residency. Yet, as we know, there are not enough of us, and the move to integrated mental health care is pursued with the goal to better equip and empower our pediatric colleagues to treat basic psychiatric illness. Thus, integration with our palliative care colleagues should utilize education, consultation, and co-management of patients with a respectful and thoughtful approach (Hirst 2011).

Given the scarcity and need for efficiency of both our fields, it behooves us to collaboratively and honestly delineate our roles and explore our knowledge gaps. A recent paper by prominent pediatric psychosomatic and palliative care leaders helped define what distinct expertise each specialty brings to the table as well as areas of overlap. Some palliative care programs will have more knowledge and resources in these middle areas than others, and identifying distinct needs is essential. For example, pediatric palliative care fellow seminars led or co-led by psychosomatic clinicians early on in their training on high occurrence and under-recognized med-psych phenomena such as delirium are particularly valuable. Many pediatric palliative care fellows only receive limited training in hyperactive delirium in the context of terminal sedation at end of life, whereas their patient population often suffers from this condition in other forms and multiple settings. Process groups for palliative care fellows led by psychiatrists to avoid burnout and increase relational knowledge as well as cross-disciplinary rotations are other types of formal integrated educational experiences of value.

Delineation of roles is also vital to help distinguish when palliative care education alone will not be sufficient. Defining unique skills and conditions can be helpful for palliative care colleagues to know when psychiatric consultation or co-management is warranted. Examples include complicated family dynamics, personality disorders, clarifying psychiatric co-morbidity, psychopharmacology, somatic symptom disorders, and others.

Often times, palliative care clinicians know how to treat symptoms and disorders but may not be able to identify or quantify them adequately; hence, psychiatry consultation is appropriate. Somatic symptom disorders and psychological factors affecting medical conditions are two entities benefitting from psychosomatic expertise. We should queue our colleagues to involve us when aggressive treatment of pain or nausea is ineffective and medically traumatic stress or anxiety may be the precipitant. Identifying this etiology can help avoid intensive opiate schedules and/or burdensome enteral feeding trials by directing efforts to desensitization, environmental changes, or more appropriate psychotropic medications. This can be a relatively low-time commitment in consultation if the palliative
Longitudinal co-management of patients is warranted for complex and pre-morbid psychiatric illness and is best performed by full integration and medical team buy-in for the presence of both psychiatry and palliative care. Treating patients with complex illness together moves beyond teaching general psychiatric evaluation and approach to palliative care clinicians and starts exploring intricate disease-specific psychosomatic expertise (Knapp et al. 2011). While the adult field has literature showing the benefits and importance of this marriage in multiple disease teams, the examples of pediatric integration and collaboration is scant. Pediatric psychosocial oncology provides the most established and prevalent psychosomatic system with this pre-existing interface. An example of this progress is the AACAP endorsement of the “Standards for Psychosocial Care of Children with Cancer and their Families” in November of last year, comprehensive benchmarks that included integration of psychiatry and palliative care in the pediatric oncology treatment team (ACCO 2015). However, other emerging integrated teams such as neurology, cystic fibrosis/muscular dystrophy, genetics/metabolism, solid organ transplant and other teams are also apt for combined pediatric palliative care inclusion and educational exchange. Palliative care clinicians should know which antidepressants to use to avoid drug-drug interactions with common anti-fungal and antibiotics used in cystic fibrosis patients. Similarly, modeling how to promote adaptive coping and set appropriate limits with patients and families in a lethal anomalies clinic is also valuable expertise, as palliative care is a field with tremendous vicarious trauma and burnout.

What Palliative Care Has to Offer Psychosomatics

Psychosomatic clinicians can gain a better understanding of patient suffering and symptoms at the end of life/disease progression from palliative care clinicians (Buxton 2015). Contrary to how our current system functions, depression and anxiety does not disappear when patients stop coming to our clinic or hospital floors near end of life – in fact, it can continue or worsen. Home and hospice psychiatric care are dire areas of need for pediatric patients. Major symptoms of end of life include anxiety, depression, nausea, and pain; areas we know well in different settings but where our palliative care colleagues can bridge our situational and disease-process knowledge gap. There are opportunities for novel treatments and therapeutic study in end of life care with their guidance and support, as demonstrated by some of the earliest studies to utilize ketamine for depression occurring in hospice settings (Iglewicz et al. 2015)—when patients have little time to wait for an SSRI to hopefully take effect.

Young psychiatrists in a recent study showed an overwhelming interest in having a psychiatric palliative care and hospice rotation (Irwin et al. 2011). When surveyed after their rotation there, a near unanimous positive response was received. One of the primary reasons clinicians enjoyed this work was the gratitude from medical teams and patients as well as profound sense of accomplishment. Providing psychiatrists with more experiences where they feel welcome, effective, and highly valued could contribute tremendously to child psychiatry trainee recruitment and prevention of burnout in our own attendings.

Psychosomatic clinicians can also benefit from the vast array of palliative care clinician mobility and delivery of care models. While psychiatrists might not be able to readily consult in patient homes or hospices, their long-standing patients can benefit directly from coordinated care by palliative care clinician collaborators as well as secondarily through the psychosocial skills we can provide to them in their practice and training.

Psychosomatic clinicians can also benefit from greater patient care acceptance through integration with palliative care teams. The stigma of psychiatry still exists, and warm hand-offs from trusted palliative care clinicians increases psychiatric utilization by previously resistant patients and families. This not only benefits the families themselves but also will invariably be well received by accountable care organizations looking for better patient adherence and decreased costs. Correspondingly, there is stigma around palliative care team involvement, often being shunned as the “death team.”

Trusted psychosomatic clinicians can help assure patient and medical team fear and death denial. Further palliative care team involvement helps obtain improved patient quality of life and symptom management, prevent psychiatric illness due to under-treated physical symptoms, and further buoy both of our services’ value and efficacy.

The recognized need for better care of children with complex chronic conditions and serious illness is a driving force and mission of many regional and national institutions. Psychosomatics and palliative care are distinct entities with specific expertise and tremendous needs but the ability to synergistically improve the care of this population. With a changing payor system and healthcare values, we can grow both our fields with a move from co-location to integration.

References


Dr. Samsel is Instructor of Psychiatry at Harvard Medical School, Pediatric Transplant Center and Psychiatry Consult Service Attending Psychiatrist at Boston Childrens Hospital, Pediatric Psychosocial Oncologist at Dana-Farber Cancer Institute.
“Until Proven Otherwise: Playing Around in Supervision”

Michael, a beginning first year resident doing his first play therapy case, came for his weekly supervision with me. He chose to present the case of Tony, a six-year-old with ADHD, who had been having increased behavior problems. From previous sessions, I knew that Tony, who lived primarily with his maternal grandparents, was probably responding to the fact that his mother had been seeing him less and less. Although Tony professed not caring about his mom’s absences and stated that he preferred to live in one house versus two, his behaviors seemed to indicate otherwise.

As Tony was reluctant to talk about his problems, Michael, at my urging, had started play therapy. Before I listened to the process notes of the play session, I set the stage for the supervision a bit: “The story of a child being raised by his grandparents is a frequent one. Until proven otherwise, family theory would posit that something has gone wrong and that the mom has ‘failed to launch.’ Do you remember Jay Haley? He is the family therapist I often talk about who wrote the book Uncommon Therapy about Milton Erickson. He also wrote another book called Leaving Home that speaks to what he feels goes wrong in ‘failure to launch’ cases. He feels it is a manifestation of separation–individuation difficulties. He proposes a treatment in which the adult is re-engaged in order to deal with issues that went wrong in the first place. I think this might be a good way to think about this case. Hypothetically, the grandparents have had difficulties with their daughter and are now having difficulties raising their daughter’s child. Now tell me what happened with Tony.”

Michael began, “Tony came late for the session. He seemed hesitant to separate from his grandmother when I met him in the waiting room. He looked back apprehensively at her as he walked to my office. As he entered my office, he went directly to the toy closet and grabbed a toy gun, which he briefly pointed at me, then pointed it around the room and quickly put it down.”

I pointed out to Michael that of all the toys in the closet, Tony had chosen a gun. Winnicott speaks of this as a “found object” that reflects the child’s issues. Winnicott would not treat this as a coincidence. I then asked Michael what he made of the play sequence.

“I’m not sure,” he responded.

“Do you remember what look Tony had on his face when he pointed the gun at you?”

“Not really,” answered Michael.

“Do you remember what you did when he pointed the gun at you?”

“I don’t remember.”

“Were you afraid?”

“No.”

“Did you act afraid?” I asked.

“No.”

“Kids pointing guns at therapists happen often in play therapy. Until proven otherwise, the theme is anger and aggression. Pay attention. When there’s gun play, think about the child and your responses. Often kids will point guns at their parents in therapy and get a very strong negative emotional response that tells the child that gun play is not allowed. Some parents ban toy guns from their houses. These parents are often subsequently upset when their children circumvent their ban by making ‘ever so deadly’ guns out of their hands that they aim at their parents. That would be the original use of handguns. In some cases, it seems like the parents have trouble differentiating play from reality. It seems to me that this gives a strong message to the kid that anger and aggression are unacceptable and not just gun play. These interchanges are often an entrée into this subject with the parents and the kids, the goal being to clarify that there is an important difference between the thoughts and deeds. As far as my interview with the child, I often join the play by asking, ‘Why are you pointing the gun at me?’ I plead for the child not to shoot me, and I ask anxiously what I have done wrong. The child responds accordingly. In some cases, they will shoot me, at which time I dramatically portray someone who has been shot complete with a dying scene fitting of a bad B movie. In most cases, the kids are thrilled and excited with my theatrics, especially when I come back to life. To paraphrase Winnicott, a good enough therapist’s job is to be destroyed and survive or to be like a Timex watch which takes a licking and keeps on ticking. In rarer cases, when I play dead, it frightens the child. This lets you know that they are especially frightened of their angry feelings. That’s why I asked you how you responded to having the gun pointed at you and how Tony responded.”

I continued, “It was interesting to me that Tony put the gun down so quickly. Until proven otherwise, I wondered if that was a ‘play inhibition,’ which is when the child has some feelings, conscious or unconscious, that derailed the play. Something happened to make him stop his play. One keeps track of these breaks in the play and tries to figure out what might be causing them. One then
uses one’s hypotheses about what’s going on to inform them as to what to do in therapy. These next actions can be kept in the play or one can try to ‘use words.’ There’s a running battle among play therapists as to whether these underlying conflicts need to be always dealt with in words. Some therapists insist that you ultimately need to put things into words, while others feel that things can be dealt with entirely within the context of the play.”

I then asked Michael what Tony did next.

“Tony then went to the closet with the toys in it and took out a box of GI Joe dolls, which he stood up and then separated into a green and a red team. He identified the red GI Joes as “bad” and the green ones as “good,” and they began to fight each other.

“And what did you make of this?”

“It seems to me that this continues the theme of anger and aggression,” said Michael.

“I would tend to agree with you on that point,” I responded, “What happened next in the play?”

Michael continued, “I then asked him why the GI Joes were fighting, and Tony answered, ‘They need to fight because if they don’t, they’ll lose, and the other team will get all the pieces.’ At that point, I didn’t know what to do.”

“What’s your best guess of what was going on?” I asked.

“I can see that we are still talking about anger issues, but I’m not sure what to do next.”

“Before I answer your question, I can’t resist telling you how GI Joe dolls came into existence. The story I heard was that they were introduced in 1963 after the success of Barbie dolls. It was noted that 49% of children, meaning boys, were not buying the dolls, as boys were culturally not supposed to play with dolls. This led some clever toy executives to invent GI Joe dolls that were not dolls but ‘action figures,’ thus opening up the market to boys.

Getting back to your question as to what to do next, you’re already doing the first thing, which is to be attentive to Tony’s play. Such attentiveness if often missing in children’s lives, especially to their play, which many parents either do not understand or worse, they feel it is stupid kid’s stuff. The next step, which you did, is to see if you can make sense of what you are paying attention to. To help you figure out what’s happening, you can ask questions about details of what is going on, such as who the characters are and what they are doing. In Tony’s play, I would ask if the GI Joes are building a fort, where they are, and what they are fighting about. When you get a sense of what’s going on, it’s usually easier to know what to say. A nice technique is to be like a sports announcer who does play-by-play. ‘The GI Joes are building forts, and they need to do that as they are at war. I’m not quite sure, but they sure are angry with each other. We will have to interview the GI Joes to get more information.’ While doing this, you are, of course, identifying and noting the child’s responses, feelings, and actions and incorporating these into your responses. You keep on going until you get a better sense of what’s going on. You can make educated guesses, which can be wrong. In these cases, you see how the child responds and keep going. I was especially struck by Tony’s comment that the winning team would get ‘all the pieces.’ That struck me as a metaphor. My first thoughts were that there were not enough resources to go around, so one needs to fight for what you feel you deserve. I personally associated that to being one of six siblings. I knew that if I was slow, the choice pieces of food would be taken, leaving me angry and envious. As they say, ‘if you snooze, you lose.’ I still eat fast and have been told this is not uncommon by others from large families. Do you remember the old mommy mommy jokes?” I asked.

“No.”

“Mommy mommy, please get me a spoon quickly. Jeremy threw up, and Johnny’s getting all the big pieces.”

“That’s gross!”

“Thank you,” I responded with a smile.

Michael noted that the idea of limited resources made him associate to the limited resources in Tony’s family. “He certainly has not had the things he has wanted due to his mother’s substance use. He’s living with his maternal grandparents and has seen his mother less and less over time. Perhaps that’s why he’s so angry.”

“That’s not a bad hypothesis,” I remarked.

Michael then returned to describing the play.

“Oh, I forgot to tell you that in the middle of the GI Joes’ fighting, he asked to go to the bathroom. Is that another play inhibition?”

“Until proven otherwise, that’s how I’d see it. Something made him uncomfortable or anxious, and people who are anxious have the urge to pee more often. Of course, the analysts might mention that he is going to check his penis; you know, that organ which is often referred to as a gun that shoots. I will leave you to see what you think about that.” I then asked Michael what happened when Tony returned from the bathroom.

He went back to the play. “One of the GI Joes jumped on top of the house of the good GI Joes, who then ran away. The GI Joe on the house yelled at the good GI Joes that he’d kill them if they came back. Then a good GI Joe and a bad GI Joe began fighting on top of the house. Tony stated that the bad guys won and that the bad guys killed all the good guys. The bad guys then knocked down the house of the good guys and took the bricks to make a new house taller than the original.”

“It’s scary when the bad guys win. Kids often find themselves dealing with good and bad and angry, war-like feelings. These can get intense enough to cause play inhibitions and bad behaviors at home. Perhaps that’s what caused Tony to stop the play. This was a great example of play therapy. I cannot wait to hear what Tony does next week.”

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Dr. Henke is a psychiatrist in New Orleans, Louisiana, and is affiliated with multiple hospitals in the area, including Children’s Hospital and Medical Center of Louisiana. He received his medical degree from Louisiana State University School of Medicine in New Orleans and has been in practice between 3-5 years. He is one of four doctors at Children’s Hospital and one of five at Medical Center of Louisiana who specialize in psychiatry.
Reminiscing About the 2016 AACAP Council Retreat

Attending the annual AACAP Council retreat in Maryland this past June was a rewarding experience. On the first day of this three-day endeavor, I quickly located my mentor and family friend, Douglas Kramer, MD. I was excited to catch up with him in our customary way, over photos of his fishing and boating expeditions in Madison, Wisconsin. I also enjoyed learning about his recent work involving treatment and advocacy for women in the criminal justice and the prison system (as well as the opportunity to sample his wit and humor). I sat with Jennifer Creedon, MD, the current John E. Schowalter, MD, Council Member, who is my co-chair of the AACAP Medical Students and Residents (MSR) Committee, and together we intermittently worked on our presentation to the Council regarding ongoing efforts and organizational work of the MSR Committee.

The retreat was an amazing experience, which allowed us to learn from the wisdom, ideas, and collaborative efforts of AACAP leadership, a group comprised of both community and academic leaders from across the country. It was a pleasure to hear our journal Editor-in-Chief Andrés Martin, MD, address the Council regarding the outstanding performance of the Journal of the Academy of Child and Adolescent Psychiatry, in addition to learning more about his Break the Cycle campaign, which raises awareness of child and adolescent mental health via a year-long bike journey (with Dr. Martin as the central biker). This event aims to increase awareness and raise funding for future research initiatives that would aid children and families suffering from mental health issues, and address disparities in access to care.

At the helm of it all, is the president of AACAP, Gregory Fritz, MD, who also serves as the director of Child and Adolescent Psychiatry at Bradley Hospital and Alpert Medical School at Brown University. His forward thinking has pioneered collaborative care between child and adolescent psychiatry and pediatrics. Learning from his balanced approach was a unique opportunity.

On the final day, Dr. Creedon and I presented our agenda as well as our annual review of projects and ongoing organizational work of the MSR Committee. We reflected on trainee recruitment and events organized by the tireless work of the MSR Committee.

In closing, the retreat was an educational experience. Members of Council, in this nurturing environment, welcomed our input from a trainee’s perspective. We appreciated learning from the leadership styles of Dr. Fritz, Executive Director Heidi Fordi, and Executive Committee members. Dr. Creedon and I ended with a note to strive towards emulating their leadership styles and skills related to organizational and training-related initiatives. These were useful lessons, especially for the future of AACAP so that evidence-based treatments, advocacy for children and families, and moving forward the field of child psychiatry can be prioritized.

Dr. Roberto is a clinical fellow in Child and Adolescent Psychiatry at Harvard Medical School, Boston Children’s Hospital, and the current Jerry M. Wiener, MD Resident Member of Council (2015-17). He may be reached at Roberto.aaron41@gmail.com.

Aaron J. Roberto, MD

DID YOU KNOW?

New York City has 4,000 street food vendors (about 13 per square mile) including hot dogs, pretzels, falafel, kebobs, and more.
Columbia, Missouri: “When I first met my teenage patient, she was terrified and scared. She presented with severe symptoms consistent with posttraumatic stress. . .(She) had been held in a local motel, tied to a bed and had to endure visits from several men daily. She could not sleep. At times it was difficult for her to speak with me through the torrent of tears. She felt hopeless and worthless. She blamed herself. She hated her life. She became suicidal.” (Adams 2016).

San Francisco, California: “(She) was sexually abused by her dad for the first time when she was 7. Her drug-addicted mom was too consumed with her own issues to get involved. . . When (she) was a sophomore in high school, she met (him), whom she did not know was a pimp. He showered her with gifts and dates, and often reminded her that no one else could possibly love her because she was “damaged.” (He) soon convinced (her) to sell her body for sex and would attack her and deprive her of food if she did not meet her quota. He kept all of the money she made and forced her to tattoo his name on her neck. (She) eventually escaped. . .” (Goldberg 2015).

New Orleans, Louisiana: “. . . a former victim of sex trafficking from Nashville, recalled being brought to cities around the South to prostitute for those attending large-scale events. . . “When they come to these kinds of events, the first thing you are told is how many you are gonna perform a day,” . . . When they give you that number, you better make that number.” Having been abducted and gang-raped by her captors at age 12, (she) said, she was one of about eight girls controlled by a ring of pimps, men who injected them with heroin and, at times, kept them handcuffed to beds. For trying to run away, she was once stabbed in the back. . .” (Martin 2013).

These are heart-breaking accounts of cases of human trafficking, which can take several forms. Two of the most common include forced labor and/or sexual exploitation. While many of us in the United States are aware that these practices occur in other parts of the world, we tend to associate such reports exclusively with developing nations. It may horrify many of us that these incidents are happening here, in our very own country. Congress defined human sex trafficking as “the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion or in which the person is induced to perform such act and has not attained 18 years of age” (U.S. Congress 2000).

In their 2014 report, the Polaris Project found evidence of sex trafficking in all 50 states, where those targeted were not immigrants or refugees, but U.S. citizens. Just in one city, the revenue from these illegal activities could reach $290 million in a year. The traffickers are psychologically savvy and seek to exploit potentially vulnerable individuals with unfulfilled promises of money, clothes, jewelry or even an emotional/romantic commitment. These forms of enticement can often lure youth who do not feel that they have adequate ties to family or community. These may be due to poverty, abandonment, or abuse; or the young person may feel any inadequate sense of belonging because of their gender, sexual orientation, substance use, or belonging to the foster care system. The commonest age group targeted is 14-21 years, but ages ranging from younger than ten to over 34 years old have been reported. Once recruited, the captors exert and maintain control through various methods of manipulation. More subtle ways include coercion, isolation from family and friends, and feigned romantic affections. Economic restriction, intimidation, forced substance abuse, and sheer violence are usual direct means of control. Unfortunately, many of the victims/survivors may continue to maintain strong emotional attachments to their trafficker (Polaris Project 2015).

Psychiatrists are now publicly and collectively responding since increased recognition of these horrific cases. During the May 2016 American Psychiatric Association legislative
assembly meeting, members worked on a position statement acknowledging human trafficking as a public health issue that impacts the mental health of its victims. They advocated for improving research, education, need to rapidly identify victims and treating their mental health needs (Iqbal 2016).

In their 2014 Journal of the American Academy of Child and Adolescent Psychiatry article, Drs. Ijadi-Maghsoodi, Todd, and Bath noted that although 28% of these youth had direct contact with health-care providers, there was a tendency not to intervene because many clinicians do not recognize the signs. They suggested greater attention to certain psychological, social and physical signs, such as the youth may appear guarded, withdrawn, or depressed, may be using substances, provide inconsistent demographic details and may be accompanied by an imposing adult. Findings on physical examination may reveal evidence of injury, branding, substance use, and other types of physical abuse. History of abortions (or asking for one), sexually transmitted infections, malnutrition, or elements consistent with a communal infectious disease may be present. Furthermore, there may be limited involvement with the larger community with poor school attendance, running away, or involvement with child protection services.

The authors concluded that child and adolescent psychiatrists should not only complete a thorough clinical assessment, but that they should also educate medical colleagues and advocate for this marginalized group in the juvenile justice systems (Ijadi-Maghsoodi 2014).

When thinking of this group of youth, the analogy of a “trick coin” comes to mind. Which is, unlike the traditional currency, a one-sided coin where the two sides are identical and the user is guaranteed of a single outcome when it is tossed to determine a wager. Unfortunately, commercial sexual exploitation of youth is a “trick coin,” where the victim is doomed to lose.

As practical steps, clinicians should find out about the resources available in their area, including shelters or non-profit endeavors. In Phoenix, the police department has a special task force dedicated to this population. Next, ensuring that this knowledge informs clinical practice, and that of co-workers, colleagues, and trainees. Any situation raising suspicion for exploitation should be reported to the authorities and the young person not allowed to return to an unsafe place.

It is possible that with a concerted action of well informed clinicians, the outcome of this coin-toss could guarantee health and safety of our youth. ■

References

Adam B (2016). Faculty Child and Adolescent Psychiatrist at University of Missouri School of Medicine. Email communication July 13, 2016


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Neurodevelopmental Disorders such as autism spectrum disorder and intellectual disability affect over two percent of people in the United States. These individuals are at high risk for developing complex psychiatric and behavioral disorders. These disorders often impede an individual’s ability to progress in educational and therapeutic programs and adversely affect family functioning.

Despite the intense needs of this population, there are very few psychiatrists with the training and experience to confidently assess co-occurring psychiatric and behavioral disorders, and to provide comprehensive, evidence-based care for affected individuals and their families. Contrary to popular perception, psychiatrists typically receive minimal training in caring for individuals with neurodevelopmental disorders. A recent study found that most child and adolescent psychiatrists in training see one to five patients with autism spectrum disorder or intellectual disability per year for outpatient and inpatient treatment of co-occurring psychiatric and behavioral disorders (Marrus et al. 2014).

Many of the developmental disability centers that have sprung up in major cities across the nation are having great difficulty recruiting psychiatrists with specific expertise in the care of this population. Consequently, wait lists to be seen by a psychiatrist are often extremely long, resulting in emergency department and inpatient visits, disrupted family systems, and risk of polypharmacy.

An efficient, high-impact strategy to address this problem is to offer specialty training in the care of those with neurodevelopmental disorders. Other areas of medicine such as palliative care, sleep, and pain medicine have successfully used this strategy to emphasize the importance of their specialty, attract talented physicians, and develop a standardized curriculum of comprehensive training experiences, in order to improve the standard of care for the targeted patient population.

In 2014, AACAP’s Autism and Intellectual Disability Committee formed a subcommittee,* chaired by Matthew Siegel, MD, and, now, Kelly McGuire, MD, MPA, to develop an advanced training program for psychiatrists to serve this population. To date, the committee has developed educational objectives and a training curriculum for a one-year, non-accredited fellowship, engaged with the Maternal Child Health Bureau and several autism foundations to explore sources of funding support and formed a growing fellowship training consortium.

The goal of the fellowship is to increase the workforce of comprehensively trained psychiatrists with expertise in the diagnosis, assessment, and treatment of autism, intellectual disability, and co-occurring psychiatric and behavioral disorders, and who are fluent in working with interdisciplinary approaches. Fellows will have the opportunity to see a high volume of affected individuals. They will develop knowledge of gold-standard diagnostic tools, multi-modal treatment approaches, and coordination of care. Fellows will gain experience in

“...The goal of the fellowship is to increase the workforce of comprehensively trained psychiatrists with expertise in the diagnosis, assessment, and treatment of autism, intellectual disability, and co-occurring psychiatric and behavioral disorders, and who are fluent in working with interdisciplinary approaches.”

* AACAP Autism and Intellectual Disability Committee Fellowship Subcommittee: Cecilia Breinbauer, MD, Dejan Budimirovic, MD, Kristin Dawson, MD, Craig Erickson, MD, Joshi Gagan, MD, Ritu Goel, MD, Antonio Hardan, MD, Jim Harris, MD, Joseph Horrigan, MD, Bryan King, MD, Kelly McGuire, MD, Tamara Palka, MD, Hannah Reed, MD, Matthew Siegel, MD, Roma Vasa, MD, Jeremy Veenstra-VanderWeele, MD, and Preston Wiles, MD.
the diagnosis of co-occurring psychiatric disorders in individuals with autism and intellectual disability and use of evidence-based psychopharmacology. Fellows will also be exposed to specific evidence-based therapies, including applied behavioral analysis, classroom models, communication supports, occupational therapy interventions, and family interventions. Fellows will be exposed to clinical research methods for the population and complete a scholarly project during the year. Fellows can also participate in coordinated didactics from experts and attend meetings at AACAP’s Annual Meeting. This broad and deep knowledge base will enable graduates of the fellowship to deliver comprehensive care, as well as serve as local experts striving to raise standards of care for this population in their eventual place of residence.

Currently, non-accredited subspecialty psychiatry fellowships in autism and intellectual disability are being offered at five academic institutions. The fellowship sub-committee will continue to develop coordinated resources for the fellowship, expand the training consortium, seek federal support for the training, and increase awareness of this unique training opportunity.

To learn more about the fellowships at AACAP’s Annual Meeting, visit the Autism and Intellectual Disability Committee booth in the Exhibit Hall Thursday, October 27, 2016, from 10 am to 4 pm.

References

Dr. McGuire is a child and adolescent psychiatrist at the Center for Autism and Developmental Disorders in Portland, Maine. She is clinical assistant professor of Psychiatry of the Tufts University School of Medicine. She may be reached at KMcGuire@MaineBehavioralHealthcare.org.

Dr. Siegel is director of the Developmental Disorders Program of Maine Behavioral Healthcare and an associate professor Psychiatry and Pediatrics of the Tufts University School of Medicine. He may be reached at Siegem@MaineBehavioralHealthcare.org.

### Subspecialty Psychiatry Training in Autism and Intellectual Disability is offered at:

**CINCINNATI CHILDREN’S HOSPITAL**, Cincinnati, Ohio  
Fellowship director: **Craig Erickson, MD**  
Contact Craig Erickson for more information (craig.erickson@cchmc.org)

**COLUMBIA UNIVERSITY and NEW YORK STATE PSYCHIATRIC INSTITUTE**, New York, New York  
Fellowship directors: **Agnes Whitaker, MD**, and **Jeremy Veenstra-VanderWeele, MD**  
Contact Jeremy Veenstra-VanderWeele (veenstra@nyspi.columbia.edu) or Agnes Whitaker (WHITAKEA@nyspi.columbia.edu) for more information

**MAINE MEDICAL CENTER**, Portland, Maine  
Fellowship director: **Matthew Siegel, MD**  
Contact Lynn Copp for more information (coppl@mainebehavioralhealthcare.org)

**MASSACHUSETTS GENERAL HOSPITAL**, Boston, Massachusetts  
Fellowship director: **Christopher McDougle, MD**  
Contact Christopher McDougle for more information (cmcdougle@mgh.harvard.edu)

**STANFORD UNIVERSITY**, Stanford, California  
Fellowship director: **Antonio Hardan, MD**  
Contact Elizabeth Archibald for more information (earchiba@stanford.edu)
Highlighting the Importance of Bullying for Today’s Child Psychiatrist

Bullying has been featured prominently in the media over the last decade and is a topic especially important for psychiatry residents, child psychiatry fellows, and practicing child and adolescent psychiatrists. Since starting my residency, I have seen many children presenting to the hospital with suicidality or depressed mood precipitated by bullying. After attending a seminar on bullying during AACAP’s Annual Meeting in 2015, I realized how much impact this behavior has on children and young adults, and how important it is to evaluate for bullying when assessing children in the hospital setting.

A uniform definition of bullying that was approved by the Centers for Disease Control and Prevention and the U.S. Department of Education is: “any unwanted aggressive behavior(s) by another youth or group of youths that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated. This harm or distress may include physical, psychological, social, or educational harm.” (IOM and NRC, 2014).

This definition can be further defined by category. Physical bullying includes hitting, kicking, punching, spitting, tripping, and pushing. Verbal bullying includes taunting, name-calling, sexual comments, or threatening words, notes, or gestures. Relational bullying includes social isolation, spreading rumors, or posting embarrassing images, sending text messages and emails (IOM and NRC, 2014; Andersen et al. 2015).

With the existence of so many types of bullying, it is not a surprise that the prevalence is quite significant. An accumulation of studies of children ranging from 5th through 12th grade in the United States showed that 20-28% of children were bullied in the past year and 28% had been bullied in the past two months (Robers et al. 2012; Eaton et al. 2012; IOM and NRC, 2014). Bullying has proven to be an international concern with one study of children aged 11 through 15 spanning over 66 countries demonstrating that 37.4% of children were bullied at least once in the past two months (Andersen et al. 2015).

Further breakdown by age and gender suggests that boys and girls experience similar rates of victimization (Cook et al. 2010). However, they find that girls are more likely than boys to have been bullied through name calling, rumor spreading, social exclusion, and cyber-bullying, while boys were more likely to have been physically bullied (Eaton et al. 2012). Bullying tends to be more common in elementary and middle school and decreases throughout the high school years (IOM and NRC, 2014; Andersen et al. 2015).

While it is eye opening to see how commonly bullying occurs, it is important to note that there is no single explanation for why some children are bullied while others are not (Andersen et al. 2015). Risk factors for being targeted include gender, age, physical appearance, health, behavior, and self-esteem, which often worsens as bullying persists (Andersen et al. 2015). Interestingly, parenting style also may increase the risk of bullying, as parents who are overprotective or have an inadequate parenting style may prevent children from developing appropriate social skills or coping mechanisms needed to resolve and handle conflicts with other peers (Andersen et al. 2015). It is important to note that being bullied once significantly increases the risk of being bullied in the future (Andersen et al. 2015).

While it is important to understand the different risk factors of being bullied, it is equally important to note the consequences. Bullying can be associated with the later development of depression, anxiety, agoraphobia, panic disorder, low self-esteem, the internalization of problems, school avoidance, and lower academic achievement (IOM and NRC, 2014; Andersen et al. 2015). Others respond with an opposite reaction which causes them to externalize behaviors, becoming aggressive and partaking in misconduct (IOM and NRC, 2014).

Perhaps the most serious consequences of bullying are suicide-related behaviors (IOM and NRC, 2014; Andersen et al. 2015). One study found being bullied in childhood predicted later suicide attempts and deaths by suicide for girls (Klomek et al. 2013). Another study found that boys that were bullied were at increased risk of suicidal thoughts (Copeland et al. 2013). The National Violent Death Reporting system found that 12 percent of youth, ages 10-17 years, who died by suicide were found to be related to bullying (Karch et al. 2013). The most significant risk factors noted for children that were bullied who also self-harmed were: family history of self-harming or suicide, cooccurring behavioral and emotional problems (conduct disorder, borderline personality characteristics, depressive or psychotic symptoms), low IQ, maltreatment by an adult, growing up in a deprived area, and previous history of bullying (Fisher et al. 2012).

Recently, I evaluated an 11-year-old child who was severely bullied in school and who had suicidal ideation. He had been subjected to bullying from kindergarten through sixth grade by multiple groups of children throughout different schools, both physically and also verbally. Factors that contributed to his being targeted for bullying included having a skin disorder, which made the appearance of his skin discolored, poor self-esteem due to his skin condition, and prior bullying. Prior

continued on page 222
to admission, the patient had not self-harmed but had been depressed about his social conditions. Unfortunately, the school was not intervening, despite pleas by his mother, and the patient began to feel as though there would be no end to his torment. He wrote a suicide note to his mother indicating his plan to jump off of a bridge after school. During school hours, the patient became upset in class and was sent to the guidance counselor where he disclosed how he felt and prompted his referral to the emergency room.

This patient was a young, well-behaved, intelligent child with the goal of becoming a psychiatrist so that he can help others. After our encounter, I started reading more about bullying and realized that he was a “classic” case. He had multiple risk factors that included being in the highest age range for bullying, being bullied multiple times, and development of depression, anxiety, and internalization of problems. Since then, I have started including a bullying evaluation in each of my emergency room consults in order to make the inpatient unit aware of this issue, so that it may be addressed with the child, parents, and, hopefully, the schools.

Many times I feel like our role as psychiatrists is to be a liaison for our patients and the community. It is unfortunate that bullying continues to occur and that schools are not intervening. I believe it is our duty to explore this issue with our patients, help them cope with the situation, treat any mood components, and educate others of the risk and consequences of bullying in the community. The more we can educate the schools and other community programs, the greater the likelihood that they will intervene if the situation arises. This will ultimately lower suicide rates and help children and adolescents develop in a supportive environment leading to a more successful future.

References

Dr. Lorenzo is a PGY2 resident at Westchester Medical Center in Valhalla, New York. She is a member of the AACAP Schools Committee. She may be reached at Aileen.Lorenzo@wmchealth.org.
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

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*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.
How Many Adolescents Had a Major Depressive Episode in the Last Year? – 1 in 9

The overall rate of major depressive episodes (MDE) rose from 9.9% in 2012-2013 to 11% in 2013-2014, according to a new report from the Substance Abuse and Mental Health Services Administration (SAMHSA), based on data from the 2012-2014 National Survey on Drug Use and Health (NSDUH) of approximately 40,000 adolescent respondents aged 12-17.

Of the 10 states with the highest rates of past year MDE among adolescents, four were in the west (Oregon, Arizona, Utah, and Washington), three in the northeast (Rhode Island, Maine, and New Hampshire), two in the Midwest (Wisconsin and Indiana), and one in the south (Virginia). Of the 10 states with the lowest rates of past year MDE among adolescents, four were in the south (Tennessee, Georgia, Kentucky, and the District of Columbia), three in the west (Alaska, New Mexico, and Hawaii), two in the Midwest (North Dakota and South Dakota), and one in the northeast (Connecticut).

Thirteen states experienced a statistically significant increase from 2012-2013 to 2013-2014 in the rates of MDE, while the remaining 37 states and the District of Columbia experienced no change in the percentage of adolescents who had an MDE in the past year.

NSDUH. The CBHSQ Report. Published online July 2016.

Children with Gender Dysphoria at Higher Risk for Self-Harm and Suicide

As transgender individuals become more visible in media and society, the number of children and youth coming out as transgender has been increasing, both in the general population and in our clinical populations. There is substantial overlap between the population that identifies as the opposite gender from that which was assigned at birth and those who experience gender dysphoria. While more transgender individuals who are transitioning are being supported by their families and communities than ever before, the pressure and stigma against transgender individuals remains devastating and dangerous to many. One such consequence of these stressors seems to be increased rates of self-harm and suicidality in those with gender dysphoria.

A recent study compared rates of suicidality and self-harm among 572 children who were referred for gender dysphoria, 425 siblings, 878 children referred to clinical care but not for gender dysphoria, and 903 children who were not referred. Answers to two items from the Child Behavior Checklist (CBCL) were compared across these groups. Of note, the CBCL is a parent-reported scale.

Children referred for gender dysphoria were more likely to harm themselves or attempt suicide, even after overall behavior problems and peer relationship problems were accounted for. Compared to the non-referred population, children with gender dysphoria were more than eight times more likely to self-harm or attempt suicide, and more than five times as likely to talk about killing themselves. These effects appeared to get worse as the children grew older.

Surprisingly, quality of peer relationships did not seem to affect self-harm or suicidality meaningfully, though overall behavior problems did.

Interestingly, these data had been collected over a period of 40 years, yet the statistics did not seem to vary according to the year of assessment. It was not clear based on these data whether increasing acceptance of transgender individuals may have any sort of effect on these measures. This study suggests that we should be screening even more rigorously for indicators of self-harm and suicidality in our patients with gender dysphoria, even as more and more youth feel supported in their transition.


Early Childhood Trauma a Risk Factor for Adolescent Substance Use

A recent study found that exposure to trauma before the age of 11 years was associated with an increased risk for early use of a variety of substances in adolescence. Children exposed to more trauma were at proportionally higher risk for early substance use.

Trauma has been studied extensively as a risk factor for substance use disorders among adults, but the link between trauma and adolescent substance use has not been as clear. Early substance use may be much more neurotoxic to the developing brain, and 90% of individuals who go on to develop substance use disorders start using drugs and alcohol before the age of 18 years. Identifying risk factors for substance use in youth may help with developing targeted prevention strategies for vulnerable populations.

Researchers using data from the National Comorbidity Survey...
Young Men With Eating Disorders May Be More Focused on Building Muscles, Leanness

Eating disorders in boys and young men are not entirely different from those in girls and young women, but whereas thinness may be the focus for female patients, leanness and muscularity appear to be of greater emphasis for male patients. And just like in female patients, male patients who experience these symptoms are at increased risk for a variety of negative mental health outcomes.

Researchers followed 7,067 young men spanning ages 13-26 years from 1999-2007 as part of the Growing Up Today Study. The study collected repeated measures on muscularity and leanness concerns as well as eating disorder behaviors (purging, overeating, binge eating, use of muscle-building products) as well as various health outcomes (obesity, drug use, binge drinking, and depressive symptoms).

Factor analyses found that 91-97% of young men would be considered part of an asymptomatic class, while the rest seemed to cluster into four symptomatic classes:

- **Body Image Disturbance** (high appearance concerns, low eating disorder behaviors; 1.0%-6.0%)
- **Binge Eating/Purging** (binge eating and purging, use of muscle-building products, low appearance concerns, 0.1%-2.5%)
- **Mostly Asymptomatic** (low levels of muscularity concern, product use, and overeating, 3.5%-5.0%)
- **Muscularity Concerns** (high muscularity concerns and use of products, 0.6%-1.0%)

Significant relationships included:

- The Body Image Disturbance group also had high rates of depressive symptoms.
- The Binge Eating/Purging and Muscularity Concerns groups had high rates of binge drinking and drug use.

Exposure to a traumatic event before age 11 years was associated with a higher risk ratio (RR) for use of:

- marijuana; RR = 1.50
- cocaine; RR = 2.78
- prescription drugs; RR = 1.80
- other drugs; RR = 1.90
- multiple drugs; RR = 1.74.

Exposure to a greater number of traumatic events was associated with even higher risk for use of marijuana, other drugs, and multiple drugs. Interpersonal violence particularly was associated with increased risk for use of all drugs.

Children who have been exposed to trauma already represent a large high-risk population who, even with treatment, are at great risk for any number of negative outcomes. However, highlighting the link between early trauma and early onset of substance use may provide an opportunity for us to target a high-risk group with early interventions that specifically address traumatic memories and coping strategies.


Most child psychiatrists feel fairly comfortable assessing more common presentations of eating disorders in girls and young women; however, when assessing eating disorder behaviors in boys and young men, clinicians should also pay particular attention to concerns about muscularity, leanness, and use of muscle-building products. Simply asking about appearance, dieting, and other inquiries focused on presentations of anorexia and bulimia may miss important information about body image problems and disordered eating in young men. Screening young men for these issues may also require questions about workout supplements, steroids, gym workouts, and body goals.

Cue-Centered Therapy for Youth Experiencing Posttraumatic Symptoms
Victor G. Carrión
Oxford University Press 2016
Paperback: 204 pages – $45.00

Cue-Centered Therapy for Youth Experiencing Posttraumatic Symptoms is a recent installment of the “Programs that Work” series by Oxford University Press. In this book, Victor G. Carrión, MD, presents a structured and multimodal intervention for children 8 years and older with posttraumatic stress disorder (PTSD). Cue-Centered Therapy (CCT) utilizes a combination of insight and cognitive, behavioral, expressive, psychological, and family approaches to target the four core domains of a response to trauma: thought, emotion, physiology, and behavior.

CCT is appropriate for a range of traumas, including physical, sexual, witnessing violence, and experiencing natural or human-made disasters. The goal of CCT is to reduce negative cognitions, foster emotional expression, identify and change trauma-related responses, empower youth, and strengthen the relationship between caregivers and their children. CCT considers the conditional process that occurs between cues and trauma and attempts to create new connections and behavioral responses to these cues. To this end, it employs a hybrid of empirically validated modalities, such as cognitive behavioral therapy (CBT), exposure, relaxation and cognitive coping skills training; art, play, and movement modalities; cognitive restructuring and processing; and psychoeducation.

CCT is a manualized therapy with active engagement of the child, caregivers, and therapist. Therapists serve as facilitators and teachers, who help children identify cues that can exacerbate symptoms and replace them with new behavioral responses.

Cue-Centered Therapy for Youth Experiencing Posttraumatic Symptoms is a well-organized and valuable clinical tool. Chapter 1 provides an introduction to CCT, considering its origins and emerging data to support its clinical effectiveness. The chapter also reviews risks of CCT and alternative treatments. Chapter 2 continues with a discussion of the diagnosis of PTSD in children, including the DSM-5 criteria and brief review of how PTSD develops from trauma exposure.

Chapter 3 presents the assessment phase of CCT while subsequent chapters work through the remaining 15 sessions of CCT. Divided into 4 phases, the 15 sessions are as follows:

1) Education for youth and caregivers; 2-3) Mindfulness, relaxation, and cognitive tools; 4-5) Chronic traumatic stress history; 6-7) Processing of the chronic traumatic stress history; 8) Mid-therapy update for youth and caregivers; 9) Approaching cues; 10) Imaginary exposure to cues; 11) Within-session exposure to cues; 12) Evaluation of in-vivo exposure assignment; 13) Processing the chronic traumatic stress history; 14) Closing session 1 for youth and caregivers; and 15) Closing session 2 for youth and caregivers.

The chapters are organized in a manual format and provide a breakdown of needed materials, overview of goals and the therapist’s role, and step-by-step instructions for each session. Illustrations, figures and forms for each session are included and are free to photocopy for clinical use. Finally, a checklist is available for the therapist to review after every session, allowing for reflection and annotation or progress notes.

Cue-Centered Therapy for Youth Experiencing Posttraumatic Symptoms continues the tradition of previous volumes in the “Programs that Work” series, offering accessible and clinically-focused material. This is a valuable addition to the library and clinical repertoire for those working with children who struggle with trauma related disorders.
The Reason I Jump: The Inner Voice of a Thirteen-Year-Old Boy with Autism

Naoki Higashida
Translated by KA Yoshida and David Mitchell
Random House 2016
(Trade Paperback Edition)
Paperback: 161 pages – $15.00

The Reason I Jump: The Inner Voice of a Thirteen-Year-Old Boy with Autism was originally published in Japanese back in 2007. Now published in 24 languages, it remains a bestselling book that continues to earn acclaim around the world. The 2016 paperback edition comes with additional content and includes a reader’s guide.

This book is about its author Naoki Higashida, who was born in 1992 and was in junior high school when the book was first published. He is unable to speak, but communicates by spelling out words with a homemade alphabet grid.

In the prelude, he eloquently proclaims why he wrote the book:

“I wrote this story in the hope that it will help you to understand how painful it is when you can’t express yourself to the people you love. If this story connects with your heart in some way, then I believe you’ll be able to connect back to the hearts of people with autism too.”

He sets out to answer 58 questions commonly asked about autism, including the following: “Q7. Why do you speak in that particular way? Q10. Why can’t you have a proper conversation? Q16. Is it true that you hate being touched? Q23. What is the worst thing about having autism? Q25. What is the reason you jump? Q51. Why do you repeat certain actions again and again? Q52. Why don’t you do what you are supposed to do, even after being told a million times? And Q55. Why can you never sit still?”

His responses provide a vivid view into his world, his longing for connection and understanding, and the peace he finds in nature. The questions are punctuated by prose pieces he had written, which are equally telling of his struggles and longings living with autism.

The 2016 paperback edition includes an introduction by David Mitchell, a celebrated author and a father of a child with autism. Both Mitchell and his wife KA Yoshida translated the book from Japanese to English. Throughout are illustrations by duo Kai and Sunny, which pay tribute to Naoki’s love of nature. The reader’s guide includes a postscript by David Mitchell, a transcript of a conversation between David Mitchell and Andrew Solomon, and 10 discussion questions.

Providing a candid and moving account of a young boy with autism, The Reason I Jump is an inspiring book for mental health providers and highly recommended to colleagues, families, friends, and others whose lives have been touched by autism.

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.

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Child and Adolescent Psychiatry – and Adult Psychiatry – Are More Different Than Pediatrics and Internal Medicine: The Case for Pediatric Integrated Care

Origins of Child Psychiatry: The First 35 Years

The “integrated care” phenomenon is interesting historically, especially for child and adolescent psychiatry. Child psychiatry began as a grassroots movement by citizens dedicated to improving the welfare of children, the social reform movements, juvenile courts, and philanthropic foundations (Richmond 1960). What emerged from this incredible cauldron in the early years of the twentieth century were the Child Guidance Clinics (Levy 1968). The Commonwealth Fund provided funding for nine early “demonstration clinics.” Aside from those clinics, the child guidance movement itself was decentralized. Each clinic was an entity unto the community it served.

The template for all the child guidance clinics was the Juvenile Psychopathic Clinic founded in 1909 in Chicago (Healy 1915). The model included the following: psychiatrists, who at that time were physicians who practiced psychiatry, although not necessarily trained in psychiatry; psychologists who did testing; and social workers who worked with parents. Not all clinics could afford a physician, according to June Synder, MA, a school psychologist at the Des Moines Child Guidance Clinic in 1947-48. In fact, her office was in a cloakroom. The services provided ranged from psychoanalytically-oriented treatment to court-involved guidance and placement assistance. All clinics worked closely with juvenile courts. They were a new entity with significant social service responsibilities.

Organizational Phase of Child Psychiatry: The Second 35 Years

It was not entirely clear in the beginning if child psychiatry would be a subspecialty of pediatrics (Richmond 1960), general psychiatry, or “a specialty in itself” (Josselyn 1962). The first child psychiatrist was a British-born neurologist, the second a pediatrician, and the third a psychiatrist. Like adult psychiatrists, child psychiatrists only offered psychotherapies but no somatic therapies at the time. A parallel but younger specialty of family psychiatry also evolved out of the child guidance movement of which the leaders were primarily child psychiatrists (Kramer 2015).

The decentralized system of guidance clinics became more centralized with the evolving organizational and training entities mostly connected to the psychiatric care of adults. For instance, approved training of child psychiatrists in the second 35 years was only allowed in child guidance clinics associated with approved general psychiatric residency programs.

The formation in 1943 of the Committee of Psychopathology of Childhood of the American Psychiatric Association (APA) ultimately led to the founding of the American Academy of Child Psychiatry (AACP) in 1953. The Group for the Advancement of Psychiatry (GAP) established a Committee on Child Psychiatry in 1947. That committee developed curricula used for years in many child psychiatry training programs (Committee on Child Psychiatry 1952).

When physicians who limited their medical practices to treating children founded the American Academy of Pediatrics in 1930, they did so separately from the American College of Physicians. The latter organization had been founded in 1915 by physicians whose specialty would ultimately be known as internal medicine. Pediatricians thus had a separate professional organization, separate training programs, and a separate examining board. They were clearly not a subspecialty of internal medicine.

Physicians who treated the emotional and behavioral problems of children and adolescents (i.e., child psychiatrists) continued to practice in child guidance clinics. They also began practicing in university, residential, state hospital, and private practice settings. The practice of child psychiatry very gradually came to include the prescribing of medications, initially first-generation antipsychotics, e.g., thioridazine. It was not until the early 1970s, however, that the treatment of the “hyperkinetic child” with psycho-stimulants began (Satterfield 1972).

Reductionistic Phase of Child Psychiatry: The Last 35 Years

Over the most recent 35 years, an increasingly reductionistic practice model evolved throughout medicine, relegating general surgery, for instance, to a few unclaimed organs between the diaphragm and the pelvis. Child and adolescent psychiatry in the mind of the public, most insurance companies, large practice entities, and community mental health centers was often reduced to the role of “prescriber.” This reductionistic cascade occurred despite the continuing comprehensive nature of child and adolescent psychiatric training requirements,
The Turning Point: Unintended Consequences

In the late ‘40s and early ‘50s, the primary role of adult psychiatrists was to staff huge state mental hospitals. Treatment modalities at the time included electroconvulsive therapy, prefrontal lobotomy (Freeman 1949), and beginning explorations with psychoanalytic psychotherapy. It did not have any overlap with the treatment of children and adolescents.

Thus, the decision in 1953 to define child psychiatry as a subspecialty of general psychiatry (Josselyn 1962) may have unintentionally contributed to the direction of child psychiatry well into the twenty-first century. For instance, the founders of AACPAP could not have predicted the future research directions of National Institute of Mental Health (NIMH). Established in 1949, NIMH for the next 60 years devoted almost all of its resources to adult presentations of mental illness, to which the treatment of children and adolescents was pigggybacked (Kramer 2014; Vitiello 2013). As a subspecialty, we were included in what made sense to NIMH for adult psychiatry. If child psychiatry had truly been a “specialty in itself,” a different path may have been followed.

From a patchwork of funding sources in a decentralized fashion across three countries and two continents, the basic science of child and adolescent psychiatry from a developmental perspective had not even been speculated about until the sciences of interaction matured in the 1990s (Kramer 2005a, 2005b, 2012, 2014, 2015).

The Case for Pediatric Integrated Care: The Next 35 Years?

The rapidly accelerating reductionism in child and adolescent psychiatry has put a brick wall between the developmental foundation of our profession and the day-to-day interactions with patients and their families. An adult psychiatry model without a clear organizing principle and of which primarily a categorical approach derived from the DSM series has superseded a comprehensive understanding of our patients. Children and adolescents need to be understood in the context of their developmental trajectories – attachment, cognitive, relational, psychosocial, psychosexual, and physical, as was as their environments – family, cultural, religious, neighborhood, school, and community.

Pediatrics and child and adolescent psychiatry share a developmental perspective, including a philosophy of care oriented toward the return of a child to her/his normal developmental path, routine cooperation with parents in evaluation, treatment, and counseling, and involvement of families in various aspects of care. Pediatricians frequently treat all the children in the same family. They often know their patients from birth. Child and adolescent psychiatrists understand individual and family dynamics in the context in which a psychiatric disorder develops, and often intervene both with the individual, and family as a whole, to facilitate recovery (Josephson 2015).

Integration or Dis-Integration? The Intersection of the Sciences of Interaction with Clinical Practice

Alignment with pediatricians will vastly and cost-effectively improve the medical and psychiatric care of children, adolescents, young adults, and families (Fritz 2016). In a capitated system, combining the existing pediatric and child and adolescent psychiatric capitation rates, in the context of an integrated practice model, perhaps under the same roof, would certainly improve care in both spheres for less combined cost. Creative approaches to medical, emotional, psychiatric, and chronic health conditions could and should be jointly developed. Programs to facilitate health and resilience beyond the individual patient model are an emerging priority for child and adolescent psychiatrists and our pediatric colleagues (Hudziak 2016).

The coup de grâce for supporting such a revolution is the emergence and maturation of the sciences of interaction (Kramer 2005a, 2015). Within the practice lives of our early and mid-career child and adolescent psychiatrists, research in at least four areas will clarify beyond anything currently imaginable the interplay between genetics and the environmental and relational context of normal and abnormal development. This includes findings in gene x environment interaction (Caspi 2006), epigenetics (Weaver 2004), dynamic neuroimaging (Kaiser 2010), and non-linear brain dynamics (Freeman 2005). Walter Freeman, Ill, MD’s (1927-2016) life work was “brain x environment” interaction from an electroneurophysiological perspective (Kramer 2005b).

Conclusion

Future developments in the sciences of interaction will direct prevention, rehabilitation, and treatment efforts rebounding to pediatric and child psychiatric health. The first step is aligning with our natural colleagues – the pediatricians.

References


Committee on Child Psychiatry (1952). The contribution of child psychiatry to pediatric training and practice, New York: Group for the Advancement of Psychiatry


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The Case for Pediatric Integrated Care continued from page 231

Kramer DA (2012). The decline of the biopsychosocial model and the demise of psychiatry. AACAP News 43(3):120-121

Dr. Kramer is emeritus clinical professor, University of Wisconsin School of Medicine and Public Health; AACAP Council counselor-at-large; and chair of the GAP Research Committee. Dr. Kramer may be reached at dakrame1@wisc.edu.

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Join Us at AACAP’s 63rd Annual Meeting!

O
n behalf of the entire Program Committee and AACAP staff, we are looking forward to seeing all of you at AACAP’s 63rd Annual Meeting, October 24–29, 2016, at the New York Hilton Midtown and the Sheraton New York Times Square in New York, NY!

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

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

■ Complimentary wireless internet throughout the meeting space at the Hilton and Sheraton

■ The AACAP App, which not only allows you to fully navigate the meeting without paper (including electronic session evaluations), but gives you access to other AACAP information (like AACAP’s Twitter feed and Member Directory) as well

■ Online tools to access a variety of meeting-related documents and plan your schedule

NEW this year, we are offering:

■ Wellness activities: Make sure to take advantage of the yoga and meditation classes, as well as exercise in Central Park

■ Outings in New York, including a Broadway show

■ Two free psychopharmacology lectures on Learning on Demand, available after the meeting

We are also pleased to welcome your families to New York. Please visit the Annual Meeting website for information on fun New York activities for children and adults alike.

With important changes in the field like integrated care, excessive use of electronics, anew challenges with children of undocumented immigrants and LGBT communities, as well as updated research in complementary medicine and psychopharmacology, you cannot afford to miss the Annual Meeting.

Visit www.aacap.org/AnnualMeeting/2016 for more information.

See you in New York,

Boris Birmaher, MD

James J. McGough, MD
Focus On…

AACAP’s 63rd Annual Meeting takes place in New York, NY, on October 24-29, 2016. The program incorporates feedback from last year’s meeting to improve the quality of the meeting. There are a wide range of topics presented at the Annual Meeting. It is an opportunity to learn new information relevant to child and adolescent psychiatrists and to obtain continuing medical education credit.

The format of the meeting ranges from small group discussions to widely attended institutes. Clinical applications, basic science, translational research, and ethical issues are among the topics discussed. Listed below are examples of some of the presentations for this year’s meeting.

The Annual Meeting is a wonderful time to interact with colleagues and friends. Please join us in New York City!

Institute 1: Psychopharmacology Update: Focus on Refractory Cases and Longer Term Outcomes *(ticket)*
Tuesday, October 25, 8:00 am – 5:15 pm
Sponsored by AACAP’s Local Arrangements Committee and Substance Abuse and Addiction Committee

Clinical Practicum 1: Integrating Mental Health, Substance Use, and Educational Services in High Risk Adolescents *(ticket)*
Tuesday, October 25, 9:00 am – 5:00 pm
Sponsored by AACAP’s Local Arrangements Committee and Substance Abuse and Addiction Committee

Symposium 9: Research Symposium: Behavioral Neuroscience *(open)*
Tuesday, October 25, 7:00 pm – 9:00 pm
Sponsored by AACAP’s Research Committee

Clinical Case Conference 4: They’re Talking About Me: Anxiety, Psychosis, or Both? *(open)*
Wednesday, October 26, 3:00 pm – 6:00 pm
Sponsored by AACAP’s Adolescent Psychiatry Committee

Symposium: 22: Child Maltreatment and Later Substance Abuse: Mechanisms of Risk and Opportunities for Intervention *(open)*
Thursday, October 27, 8:30 am – 11:30 am
Sponsored by AACAP’s Child Maltreatment and Violence Committee

Town Meeting: Should AACAP’s Affiliate Member Status Be Expanded to Include Psychologists? *(AACAP members only)*
Thursday, October 27, 11:45 am – 1:15 pm
Sponsored by AACAP’s Child Maltreatment and Violence Committee

Symposium 31: Transmission of Major Depression Across Three Generations: Search for Biomarkers *(open)*
Thursday, October 27, 2:00 pm – 5:00 pm

Workshop 23: The Inconsolable Child Clinical Assessment and Standardized Tools for Differentiating Anxiety, Pain, Sleep Problems and Delirium in Infants and Small Children *(ticket)*
Thursday, October 27, 2:00 pm – 5:00 pm
Sponsored by AACAP’s Infant and Preschool Committee and Physically Ill Child Committee

Symposium 36: Early-Morning Functioning in Attention-Deficit/Hyperactivity Disorder: Impact, Measurement, and Treatment Considerations *(open)*
Friday, October 28, 8:30 am – 11:30 am

Clinical Perspectives 35: Can Brain Imaging Change the Game for Child and Adolescent Mental Health? A Look at Today and Tomorrow *(open)*
Friday, October 28, 1:30 pm – 4:30 pm

Symposium 42: Anxiety in Individuals With Autism Spectrum Disorder: Clinical Assessment, Biology, and Treatments *(open)*
Saturday, October 29, 8:30 am – 11:30 am

Clinical Case Conference 13: Child Sexual Abuse Case Reports: Importance, Misuse, and Ethical and Legal Issues *(open)*
Saturday, October 29, 1:30 pm – 4:30 pm
Sponsored by AACAP’s Child Maltreatment and Violence Committee
RESEARCH SYMPOSIUM
Behavioral Neuroscience
Tuesday, October 25, 7:00 pm–9:00 pm (open)
Chair: Moira A. Rynn, MD
Speakers: Nim Tottenham, PhD, Regina M. Sullivan, PhD

Nim Tottenham, PhD, is a developmental affective neuroscientist researching the development of the neurobiology associated with mature emotion regulation in humans. Her research has highlighted fundamental changes in amygdala-prefrontal cortex circuitry across childhood and adolescence and the powerful role that early experiences, such as caregiving, have on the developmental trajectories of these circuits. Her research uses functional magnetic resonance imaging (fMRI), behavioral, and physiological methods to examine human limbic-cortical development in children and adolescents as well as their parents. The title of her talk is: Development of Human Emotion Regulation Neurobiology and the Role of the Caregiver.

Regina M. Sullivan, PhD, is a developmental behavioral neuroscientist researching the neurobiology of infant attachment to the caregiver to determine the neural mechanisms for the enduring mental health effects of abuse and trauma in early life. Her research has highlighted how the infant brain functions differently from the adult brain, as well as the critical role of the caregiver in modifying how the young brain responds to trauma. The title of her talk is: Caregiver Presence Modifies Neural Networks Processing of Trauma in Infancy.

Sponsored by AACAP’s Research Committee and Supported by the Research Initiative.

KARL MENNINGER, MD, PLENARY
A Common Struggle: A Personal Journey Through the Past and Future of Mental Illness and Addiction
Wednesday, October 26, 8:00 am–9:45 am (open)
Chair: Gregory K. Fritz, MD, AACAP President
Speaker: The Honorable Patrick J. Kennedy

The Honorable Patrick J. Kennedy is a former member of the United States House of Representatives and the nation’s leading political voice on mental illness, addiction, and other brain diseases. During his 16-year career representing Rhode Island in Congress, he fought a national battle to end medical and societal discrimination against these illnesses, highlighted by his lead sponsorship of the Mental Health Parity and Addiction Equity Act of 2008—and his brave openness about his own health challenges. The son of Senator Edward “Ted” Kennedy, he decided to leave Congress not long after his father’s death to devote his career to advocacy for brain diseases and to create a new, healthier life and start a family. He has since founded the Kennedy Forum, which unites the community of mental health, and co-founded One Mind for Research, a global leader in open science collaboration in brain research. Kennedy is also the co-author of A Common Struggle, which outlines both his personal story and a bold plan for the future of mental health in America.

The Karl Menninger, MD, Plenary is supported by Ronald K. Filippi, MD, in honor of his mentor, Karl Menninger, MD.
JAMES C. HARRIS, MD, DEVELOPMENTAL NEUROPSYCHIATRY FORUM
Understanding Autism in Families:
From Leo Kanner to Developmental Neurobiology
Thursday, October 27, 9:00 am–11:30 am (open)
Chairs: Bryan H. King, MD, Jeremy Veenstra-VanderWeele, MD
Speakers: Joseph Piven, MD, Jason Wolff, PhD

For 2016, AACAP is pleased to present the inaugural James C. Harris, MD, Developmental Neuropsychiatry Forum, a program that will be an annual event thanks to a generous donation from AACAP Distinguished Fellow James C. Harris, MD, and his wife Catherine DeAngelis, MD, MPH. The Forum provides the opportunity for Annual Meeting attendees to learn about cutting-edge science in this evolving subspecialty area of child and adolescent psychiatry.

This year’s Forum details the risk of autism spectrum disorder (ASD) and related traits within families. It focuses on how this familial recurrence impacts current clinical management, as well as promising avenues for future impact, including early detection of infants at high risk of ASD.

Joseph Piven, MD, is a child and adolescent psychiatrist and a leader in developmental neuropsychiatry research, including seminal work on the broad autism phenotype in families, as well as more recent work on brain development in children at high familial risk of autism spectrum disorder. Dr. Piven places family risk of autism and related traits in a historical and clinical context. He highlights Leo Kanner’s initial observations and traces his influence through later work on genetic risk, as well as research on autism traits within families. To set the stage for a discussion of developmental neurobiology, he frames the high risk of ASD in younger siblings of children with autism as both a clinical challenge and as a research opportunity.

Jason Wolff, PhD, is a rising star in developmental cognitive neuroscience using neuroimaging. His research examines trajectories of brain development in autism, links between brain development and later behavior, and potential clinical applications. Dr. Wolff describes exciting recent findings suggesting that abnormal trajectories in brain development precede an autism diagnosis in high-risk infants. Within emerging data sets, specific symptoms also map onto particular changes in brain structure or development.

During the discussion, both speakers describe how an understanding of autism within families impacts clinical practice currently, and how emerging research findings may improve future care of children with ASD and their families.

The James C. Harris, MD, Developmental Neuropsychiatry Forum is supported by AACAP Distinguished Fellow James C. Harris, MD, and his wife Catherine DeAngelis, MD, MPH.
TOWN MEETING
Should AACAP’s Affiliate Member Status Be Expanded to Include Psychologists?
Thursday, October 27, 11:45 am–1:15 pm (AACAP members only)

The purpose of this Town Meeting is to discuss the merits of extending membership to psychologists. At the present time, many of our peer organizations include psychologists as affiliate members. Child psychiatrists as interdisciplinary professionals already collaborate with psychologists in our clinical, academic, and research activities. Psychologists are frequent and consistent contributors to our Annual Meetings, JAACAP, and our clinical practices. Furthermore, the changing healthcare environment calls for increasing collaboration between interdisciplinary professionals. At this meeting we discuss the benefits and potential disadvantages of inviting psychology membership in AACAP.

LAWRENCE A. STONE, MD, PLENARY
Child Psychiatry: Population Health’s Reluctant Driver
Saturday, October 29
11:45 am–1:15 pm (open)

Kelly J. Kelleher, MD, is professor of Pediatrics, Psychiatry, and Public Health in the Colleges of Medicine and Public Health at The Ohio State University, vice president of Community Health and Services Research at Nationwide Children’s Hospital, and center director in the Center for Innovation in Pediatric Practice at The Research Institute at Nationwide Children’s Hospital in Columbus, Ohio. He is a pediatrician and health services researcher focused on improving policy for, and the practice of, pediatric care for high risk children adversely affected by poverty, violence, neglect, alcohol, drug use, or mental disorders. He serves or has served on several committees for the National Academy of Medicine and the American Academy of Pediatrics.

In his lecture, Dr. Kelleher explores how the radical transformation of the child healthcare system, generally and pediatrics specifically, is largely being driven by economic pressures. These pressures, combined with large scale consolidation and technology disruption, are also creating opportunity to develop population health systems. Under the title of “value-based purchasing,” population health goals and efficiencies are altering the structure of routine pediatric care. Behavioral issues are emerging as the most important factors in both outcomes and costs for large networks. Child psychiatry research, policy, and practice have the potential to greatly influence the shape of large networks caring for U.S. children, but only with considerable re-shaping of practice, assertive leadership from the field, and a developmental perspective on the family and child in neighborhoods.

The Lawrence A. Stone, MD, Plenary is named in honor of AACAP Past President and Life Fellow, Lawrence A. Stone, MD. It recognizes his leadership, vision, and passion for the mission of AACAP. Mrs. Marnette Stone endowed this plenary in loving tribute to her husband.
Discover New York!

Here are just a couple of highlights of what New York has to offer. For more detailed descriptions, along with a longer list of activities, visit www.nycgo.com.

Delegate Discount Pass

The Delegate Discount Pass is your ultimate guide to exclusive savings throughout the City. Redeem this offer by showing a printed or mobile version of the NYC & Company Delegate Discount Pass in its entirety at participating member restaurants and attractions, unless provided with a promo code for advance reservations, purchase, or registration. Click here to download: www.aacap.org/app_themes/aacap/Docs/cme_and_meetings/annual_meeting/2016/Delegate_Discount_Pass.pdf.

Discount Broadway Tickets

You will not want to miss out on all the great plays and musicals that Broadway has to offer! NYC & Company has discounted tickets available for your disposal! Visit: www.theatermania.com/nycgo/.

NYC Museums

No trip to New York City is complete without experiencing some of its world-class cultural institutions, and Museum Mile is a good place to start. This stretch of Fifth Avenue, from East 82nd to East 105th Streets—actually measuring a little longer than a mile—lays claim to one of the world’s densest concentrations of culture. Museums along the “Mile” include The Metropolitan Museum of Art, Neue Galerie, the Solomon R. Guggenheim Museum, the National Academy Museum and School, Cooper Hewitt, National Design Museum, the Jewish Museum, the Museum of the City of New York, and El Museo del Barrio.

TV Show Tapings

It’s fun—and free—to attend the tapings of popular television shows shot in New York City. You get to see huge stars up close, and if you are lucky, your friends at home might even see you on TV. The wait for advance tickets is often long, so it is best to write in for them or reserve online far before your desired date. Still, many shows have standby options if you are willing to wait in line. Visit: www.nycgo.com/articles/tv-show-tapings.
**Family Friendly Fun in New York**

**Tuesday, October 25, 2016**

**Children’s Welcome Event at the New York Hilton Midtown**
11:30 am-1:00 pm

Bringing your children or grandchildren to AACAP’s Annual Meeting? Start the week off by meeting other families who also have kids to entertain in the City that Doesn’t Sleep at the Children’s Welcome Event. We’ll provide some fall crafts and activities as well as light treats for the kids. All are welcome, but all children should be supervised by an adult.

**Wednesday, October 26, 2016**

**Children’s Museum of Manhattan**
Meet at 10:00 am at the Hospitality Desk on the 2nd Floor Promenade of the Hilton Hotel

The Children’s Museum of Manhattan (CMOM) inspires children and families to learn about themselves and our culturally diverse world through a unique environment of interactive exhibitions and programs. Since opening in a neighborhood storefront in 1973, CMOM has grown into a unique 38,000 square-foot learning facility with outreach programs at nearly 50 sites throughout New York City.

**Admission:**
Children and Adults - $12, Seniors (65 & older) - $8
Children under 12 months - Free

**Thursday, October 27, 2016**

**Brooklyn Children’s Museum**
Meet at 10:00 am at the Hospitality Desk on the 2nd Floor Promenade of the Hilton Hotel

The mission of Brooklyn Children’s Museum is to engage children in educational and entertaining experiences through innovation and excellence in exhibitions, programs, and use of its collection. The Museum encourages children from infancy through high school to develop an understanding of and respect for themselves, others and the world around them.

**Admission:**
$11 PER PERSON, 12 months & under - free

**Friday, October 28, 2016**

**Central Park Zoo**
Meet at 10:00 am at the Hospitality Desk on the 2nd Floor Promenade of the Hilton Hotel

Spanning 843 acres in the heart of Manhattan, Central Park is one of the world’s greatest urban oases, encompassing a diverse landscape of rolling fields, walking trails, and tranquil bodies of water—all sculpted by human hands. Among its attractions are the Central Park Zoo, Belvedere Castle, and the Friedsam Memorial Carousel (which, weather permitting, operates seven days a week from April through October and intermittently the rest of the year). Sheep Meadow and the Great Lawn offer sprawling expanses where visitors can relax and enjoy the outdoors.

**General Admission:**
Adult (13 & over) - $12, Senior (65 & over) - $9
Child (3-12) - $7, Child (2 & under) - FREE
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.
FOR YOUR INFORMATION

Guide to Exhibits

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

Plan your trip to the Exhibit Hall before the meeting by viewing an interactive exhibit hall floor plan on AACAP’s website at aacap.confex.com/aacap/2016/exhibitorboothmap.cgi?password.

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

The Exhibit Hall is located in Americas Hall I and II on the Third and Fourth Floors of the New York Hilton Midtown.

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For the treatment of **Attention Deficit Hyperactivity Disorder (ADHD)** in children aged 6 years and older

**Introducing DYNANVEL™ XR**

The first and only extended-release liquid amphetamine for ADHD

**INDICATION**

DYNANVEL™ XR (amphetamine) extended-release oral suspension is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

**IMPORTANT SAFETY INFORMATION**

**WARNING: ABUSE AND DEPENDENCE**

CNS stimulants, including DYNANVEL XR, other amphetamine-containing products, and methylphenidate, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

- **DYANAVEL XR** is contraindicated
  - In patients known to be hypersensitive to amphetamine, or other components of DYANAVEL XR. Hypersensitivity reactions, such as angioedema and anaphylactic reactions, have been reported
  - During treatment with monoamine oxidase inhibitors (MAOIs) and within 14 days following discontinuation of treatment with an MAOI because of the risk of hypertensive crisis

- Prior to and during treatment assess for the presence of cardiac disease. Sudden death, stroke and myocardial infarction have been reported in adults with CNS stimulant treatment at recommended doses. Sudden death has been reported in children and adolescents with structural cardiac abnormalities and other serious heart problems taking CNS stimulants at recommended doses for ADHD. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious heart arrhythmia, coronary artery disease, and other serious heart problems. Further evaluate patients who develop exertional chest pain, unexplained syncope, or arrhythmias during DYANAVEL XR treatment.

- CNS stimulants can cause increases in blood pressure (mean increase about 2-4 mm Hg) and heart rate (mean increase about 3-6 bpm). Monitor all patients for tachycardia and hypertension.

- CNS stimulants may cause psychotic or manic symptoms in patients with no prior history, or exacerbation of symptoms in patients with pre-existing psychiatric illness. Prior to treatment, assess for the presence of bipolar disorder.

- CNS stimulants have been associated with weight loss and slowing of growth rate in pediatric patients with ADHD. Monitor weight and height in children during treatment with DYANAVEL XR. Treatment may need to be interrupted in children not growing as expected.
Customize the **DYANAVEL XR** dose* to their responses and needs

*The starting dose is 2.5 or 5 mg, taken once-daily in the morning with or without food, may be titrated by 2.5 to 10 mg per day, every 4 to 7 days, up to a maximum dose of 20 mg per day. Periodically re-evaluate long-term use and adjust dosage as needed.

- Low starting dose options and the ability to titrate within one prescription
- Optimize the dose to balance symptom control and side effects
- Prior to treatment assess for cardiac disease and risk for abuse
- After prescribing, keep prescription records, educate about and monitor for abuse and overdose, and re-evaluate the need for DYANAVEL XR use

### If switching from other amphetamine products to DYANAVEL XR

- To switch from another amphetamine product, discontinue treatment, then follow the titration schedule for DYANAVEL XR
- Do not substitute for other amphetamine products on a mg-per-mg basis because of different amphetamine base compositions and differing pharmacokinetic profiles

See Full Prescribing Information for complete Dosing and Administration.

- CNS stimulants, including DYANAVEL XR, are associated with peripheral vasculopathy, including Raynaud’s phenomenon. Signs and symptoms are usually intermittent and mild; very rare sequelae include digital ulceration and/or soft tissue breakdown. Careful observation for digital changes is necessary during treatment with ADHD stimulants.
- Most common adverse reactions observed with amphetamine products: dry mouth, anorexia, weight loss, abdominal pain, nausea, insomnia, restlessness, emotional lability, dizziness, and tachycardia. There is limited experience with DYANAVEL XR in controlled trials. Based on this limited experience, the adverse reaction profile of DYANAVEL XR appears similar to other amphetamine extended-release products. The most common (≥2% in the DYANAVEL XR group and greater than placebo) adverse reactions reported in the Phase 3 controlled study conducted in 108 patients with ADHD (aged 6–12 years) were: epistaxis (DYANAVEL XR 4%, placebo 0%), allergic rhinitis (4%, 0%) and upper abdominal pain (4%, 2%).
- DYANAVEL XR use during pregnancy may cause fetal harm.
- Breastfeeding is not recommended during treatment with DYANAVEL XR.

Please see additional Important Safety Information, including Boxed Warning regarding potential for Abuse and Dependence, and Brief Summary of Full Prescribing Information on next page.


NEW

**Dyanavel XR**

(amphetamine) extended-release oral suspension 2.5 mg/mL
dyanavelxrpro.com
DYANAVEL™ XR (amphetamine) extended-release oral suspension, CII 2.5 mg/mL

BRIEF SUMMARY: See Full Prescribing Information for complete product information.

WARNING: ABUSE AND DEPENDENCE

CNS stimulants, including DYANAVEL XR, other amphetamine-containing products, and methylenidate, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

INDICATIONS AND USAGE

DYANAVEL XR is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

CONTRAINDICATIONS

DYANAVEL XR is contraindicated. In patients known to be hypersensitive to amphetamine, or other components of DYANAVEL XR, hypersensitivity reactions such as angioneuroedema and anaphylactic reactions have been reported in patients treated with other amphetamine products. During treatment with MAOIs, and also within 14 days of following discontinuation of treatment with a MAOI, because of risk of hypertensive crisis.

WARNINGS AND PRECAUTIONS

Potential for Abuse and Dependence (See Boxed Warning above).

Serious Cardiovascular Reactions Sudden death, stroke, myocardial infarction were reported in adults with CNS stimulant treatment at recommended doses. Sudden death reported in children and adolescents with structural cardiac abnormalities and other serious heart problems taking CNS stimulants at recommended doses for ADHD. Avoid use with known structural cardiac abnormalities, cardiomyopathy, serious heart arrhythmias, coronary artery disease, and other serious heart problems. Further evaluate patients who develop exertional chest pain, unexplained syncope, or arrhythmias during DYANAVEL XR treatment.

Blood Pressure / Heart Rate Increases CNS stimulants cause increase in blood pressure (mean increase 2-4 mm Hg) and heart rate (mean increase 3-6 bpm). Monitor for potential tachycardia and hypertension.

Psychiatric Adverse Reactions Exacerbation of Psychotic Behavior CNS stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with pre-existing psychotic disorder.

Rebound of a Manic Episode in Patients with Bipolar Illness CNS stimulants may induce mixed or manic episode in patients with bipolar disorder. Prior to initiating treatment, screen patients for risk for developing a manic episode. New Psychotic or Manic Symptoms CNS stimulants, at recommended doses, may cause psychotic or manic symptoms in children without prior history of psychotic illness or mania. If such symptoms occur, consider discontinuing DYANAVEL XR. In pooled analysis of multiple short-term, placebo-controlled studies of CNS stimulants, psychotic or manic symptoms occurred in 0.1% of CNS stimulant-treated compared to 0% in placebo-treated patients.

Long-Term Suppression of Growth CNS stimulants were associated with weight loss and slowing growth rate in pediatric patients. Closely monitor growth (weight, height) in pediatrics treated with CNS stimulants, including DYANAVEL XR.

Peripheral Vasculopathy, including Raynaud’s Phenomenon Stimulants, including DYANAVEL XR are associated with peripheral vasculopathy, including Raynaud’s phenomenon. Signs, symptoms are usually intermittent and mild; however, very rare sequelae include digital ulceration and/or soft tissue breakdown. Effects were observed in post-marketing reports at different times, therapeutic doses in all age groups through treatment. Signs, symptoms generally improve after dose reduction or discontinuation of drug. Careful observation for digital changes is necessary during treatment. Further clinical evaluation (e.g., rheumatology referral) may be appropriate for certain patients.

ADVERSE REACTIONS

Clinical Trial Experience Because clinical trials are conducted under varying conditions, adverse reactions rates observed in clinical trials of a drug cannot be directly compared to rates in clinical trials of another drug and may not reflect rates observed in clinical practice. With Other Amphetamine Products in Pediatric Patients and Adults with ADHD Cardiovascular: Palpitations, tachycardia, elevation of blood pressure, sudden death, myocardial infarction. There were isolated reports of cardiomyopathy associated with chronic amphetamine use. CNS: Psychotic episodes at recommended doses, overstimulation, restlessness, irritability, euphoria, dyskinesia, dysphoria, depression, tremor, tics, aggression, anger, legothee, insomnia, emotional liability and diziness. Eye Disorders: Vision blurred, mydriasis. Gastrointestinal: Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. Anorexia, weight loss may occur as undesirable effects. Allergic: Urticaria, rash, hypersensitivity reactions including angioneuroedema and anaphylaxis. Serious skin rashes, including Stevens-Johnson syndrome and toxic epidermal necrolysis were reported. Endocrine: Impotence, changes in libido. Skin: Alopecia. With DYANAVEL XR in Pediatric Patients with ADHD There is limited experience with DYANAVEL XR in controlled trials. Based on this, the adverse reaction profile of DYANAVEL XR appears similar to other amphetamine extended-release products. Most common (≥2% DYANAVEL XR group and greater than placebo) adverse reactions reported in Phase 3 controlled study conducted in n=106 with ADHD (aged 6-12 yrs) were: epistaxis, allergic rinitis, upper abdominal pain.

Table 1. Common Adverse Reactions Occurring in ≥2% of Subjects on DYANAVEL XR & greater than Placebo during double blind phase.

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>DYANAVEL XR (N=52)</th>
<th>Placebo (N=48)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory, thoracic and mediastinal disorders</td>
<td>3.8%</td>
<td>0%</td>
</tr>
<tr>
<td>Rhinitis allergic</td>
<td>3.6%</td>
<td>0%</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>3.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Abdominal pain greater</td>
<td>3.8%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Postmarketing Experience Adverse reactions were identified during post approval of other amphetamine products. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate a frequency or establish a causal relationship to drug exposure.

Drug Interactions Drugs Having Clinically Important Interactions with Amphetamines MAO-I MAO-I antidepressants slow amphetamine metabolism, increasing amphetamines effect on release of norepinephrine and other monoamines from adrenergic nerve endings causing headaches and other signs of hypertensive crisis. Toxic neurological effects and malignant hyperpyrexia can occur, sometimes with fatal results. Interaction: Do not administer DYANAVEL XR during or within 14 days following administration of MAOI. Avoiding Agents: Increase blood levels and potentiate action of amphetamine. Interaction: Co-administration of DYANAVEL XR and gastrointestinal alkalinizing agents should be avoided. Acidifying Agents: Lower blood levels and efficacy of amphetamines. Interaction: Increase dose based on clinical response. Trough Monitoring: May enhance activity of tricyclic or sympathomimetic agents causing sedation, and sustained increases in concentration of d-amphetamine in brain. Cardiovascular effects can be potentiated. Intervention: Monitor frequently, adjust or use alternative therapy based on clinical response. Proton Pump Inhibitors: Time to maximum concentration (Tmax) of amphetamine is increased compared to when administered alone. Intervention: Monitor patients for changes in clinical effect, adjust therapy based on clinical response.

Drug/Laboratory Interactions: Amphetamines can cause elevation in plasma corticosteroids. This is greatest in the evening. Amphetamines may interfere with urinary steroid determinations.

USE IN SPECIFIC POPULATIONS

Pregnancy Risk Summary - There are limited published data on amphetamines in pregnant women. Data are insufficient to determine drug-associated risk of major congenital malformations or miscarriage. Adverse pregnancy outcomes, including premature delivery, low birth weight, infants born to mothers dependent on amphetamines. DYANAVEL XR may cause fetal harm. Lactation Risk Summary - Based on limited case reports in published literature, amphetamine (d- or l, d) is present in human milk, at relative infant doses of 2% - 13.8% of maternal weight-adjusted dosage and milk/plasma ratio ranging 1.9 to 7.5. Because of potential for serious adverse reactions in breastfed infant, advise patients breastfeeding is not recommended during treatment with DYANAVEL XR. Pediatric Use Safety and effectiveness were established in patients with ADHD ages 6-17. Safety and efficacy in patients younger than 6 yrs with ADHD have not been established. Geriatric Use DYANAVEL XR has not been studied in geriatrics.

DRUG ABUSE AND DEPENDENCE

Controlled Substance DYANAVEL XR contains amphetamine, which is a Schedule II controlled substance in the U.S. Controlled Substance Act.

OVERDOSAGE Consult with a Certified Poison Control Center (1-800-222-1222) for up-to-date guidance and advice for treatment of overdose. Individual patient response varies widely. Toxic symptoms may occur ideosyncratically at low doses. Manifestations of overdose include restlessness, tremor, hyperventilation, rapid respiration, confusion, agitation, headache, and panic states, hyperpyrexia, and rhabdomyolysis. Fatigue and depression usually follow CNS stimulation. Others include arrhythmias, hypertension or hypotension, circulatory collapse, nausea, vomiting, diarrhea, abdominal cramps. Fatal poisoning usually preceded by convulsions and coma.

Manufactured by: Tris Pharma, Inc., Monmouth Junction, NJ 08852 www.trispharma.com Based on LB 8417-R, Rev02 DYANAVEL is a trademark of Tris Pharma, Inc. DHR-0005(1) 06/16 © 2016 Tris Pharma, Inc. All rights reserved.
Renew Early for 2017

Don’t procrastinate! Make the effort and get it out of the way! AACAP 2017 dues invoices drops in early October.

Renew today at www.aacap.org!

Members are mailed dues invoices the first week of October to encourage early renewal.

In Memoriam

Klaus Minde, MD
Westmount, QC, Canada

Paul Wender, MD
Andover, MA

AACAP was informed of the individuals in the time spanning August-September 2016. If you find an error, please accept our apologies and contact the Communications Department at communications@aacap.org or 202.966.7300 ext. 119.
Welcome New AACAP Members

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Why I Chose to Name AACAP in My Will, and Why I Hope You Will Join Me

Michael Maloney, MD
Cincinnati, OH
AACAP Member since 1976

So, why did I name AACAP 1953 Society in my will and trust? The story begins in October of the Bicentennial Year 1976. I had just finished training as a child psychiatrist and was attending my first Annual Meeting of AACAP. Not knowing what to expect, I was anxious about meeting other child psychiatrists. Would they be as narcissistic and aloof as many of the adult psychiatrists I met during my residency and at American Psychiatric Association local and national meetings? To my surprise all the child psychiatrists from across the country seemed friendly, open, and actually interested in getting to know my wife and me. A few even took interest in my career and became lifelong mentors. Even the AACAP staff was outgoing, helpful, and reliable when needed.

Year after year, this positive experience has been repeated at annual meetings. For a while, I served on AACAP committees, meeting with some of the best and brightest from around the world. Those relationships helped me in my career as a faculty member and, now, with referrals in private practice. Through the years Executive Director Ginger Anthony and many other staff members have provided me with information, support, and networking connections which have been priceless.

AACAP has acted as a professional family for me since 1976, always there in times of stress, celebration or learning. Now, it is my turn to pay back the AACAP for being there for me since 1976. I feel honored that part of my estate will help AACAP to support future child and adolescent psychiatrists throughout their careers. Our generation’s donations will guarantee the continuation of AACAP’s important work. Donations of any amount are welcomed by AACAP. Please join me so that our pledged gifts can be added together to achieve even more impact throughout the coming decades.
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.

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* Indicates an honorarium donation
♥ 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.
Life Insurance for Your AACAP Family

Life insurance is an asset you may not think of donating to AACAP until you understand how powerful, practical, and simple it can be. It can be used to create a much greater philanthropic impact at AACAP than you might have thought possible.

When You Designate AACAP as Beneficiary

You can create a wonderful legacy by designating AACAP as a partial or full beneficiary of an existing policy. You will retain ownership of the policy and the flexibility to change your beneficiary designation later if your circumstances change, but any policy proceeds distributed to AACAP will be exempt from estate tax in your estate and create a wonderful legacy at comparatively low cost.

Three Ways to Gift Life Insurance to AACAP

1. **Designate** AACAP as beneficiary of your current life insurance policy; or
2. **Purchase** a new policy and name AACAP as the owner and beneficiary. You will then be asked to contribute the equivalent of the annual premium to AACAP. This premium contribution is tax-deductible and is used by AACAP to pay the insurance premium; or
3. **Give** AACAP a fully paid life insurance policy that your family obligations no longer require.

To learn more or tell us of your life insurance plans, please contact Development by e-mail at development@aacap.org, call us at 202.966.7300, x140, or visit www.aacap.org/1953_Society.

Life Members Reach 140!

No, not 140 years old. But, **140 lives you have impacted.**

**Impact.**

Since 2010, the Life Members Fund has made an investment in **75 residents and 65 medical students.** That’s potentially **140 next generation child and adolescent psychiatrists.** And, **future Owls!**

**Donate.**

This achievement is remarkable. We are at a time of health care change when our skills have never been more important, but the deficit of available child and adolescent psychiatrists is growing. Life Members can, and are, closing this gap. Let’s keep it up.

**To donate, visit www.aacap.org/donate.**

**NEW:** There is another way you can donate and do more to close the child psychiatry gap. Consider joining the 1953 Society. Visit [www.aacap.org/1953_Society](http://www.aacap.org/1953_Society) to learn more.

Stay involved. Stay connected to all Life Members activities, programs, and photos by reading the Life Members Owl eNewsletter.

**2016 Owl Pin.** Remember, if you donate $450 or more to the Life Members Fund by October 31, 2016, you will receive a limited edition 63rd Anniversary OWL PIN!
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.

*revised 10/2012
Danger from firearms is a disturbing reality in the lives of our children and adolescents. Almost one-third of all homes contain guns with estimates that 50 million Americans own 300 million guns. Despite continuing educational efforts, the majority of these guns are kept loaded, unlocked, and potentially accessible to children. Research indicates that if a gun is stored in a home, the risk of homicide increases threefold and the risk of suicide increases up to fivefold.

Children and adolescents have easy access to guns. Over 5% of high school students indicated that they carried a gun in the past month, and it is estimated that approximately one million children bring guns to school each year. Many students who carry guns do so because they are afraid or influenced by peer pressure. Research on brain development demonstrates that young children have difficulty accurately assessing risk, and that adolescents are actually drawn to risk taking behavior. These developmental considerations make access to guns particularly dangerous for children and adolescents.

The United States has the highest rates of firearm-related deaths among industrialized countries, including homicide, suicide, and unintentional deaths; and young people are often the victims. Gun violence accounts for almost 4,000 deaths and over 15,000 injuries each year among children and adolescents. The rate of firearm-related homicides for U.S. children younger than 15 years of age is nearly 16 times greater than the rates in 25 other industrialized countries combined.

Child and adolescent psychiatrists have been active in advocating for reasonable firearm policies. AACAP believes that the most effective measure to help prevent firearm-related deaths and injuries to children and adolescents is to reduce the presence of guns in homes and communities. This is particularly critical for homes or families in which the threat of personal violence exists. AACAP also supports all efforts to educate children and the general public about the danger of guns, and the increased risk of accidental injury and death associated with gun ownership. Due to their inherent impulsivity, any and all access to firearms by youth must be restricted, controlled and closely supervised. AACAP further supports increased funding for research on gun safety and the prevention of gun related violence, and opposes legislative efforts to restrict or inhibit such initiatives. Additionally, AACAP encourages the strict enforcement of existing laws pertaining to the purchase, ownership and storage of firearms, as well as safety measures such as trigger locks, extended waiting periods, mandatory background checks for all transactions related to gun ownership, and other initiatives designed to protect children and reduce the incidence of gun related violence. Finally, AACAP opposes legislative efforts to limit, restrict, or interfere with clinical inquiries by physicians about the presence of and access to firearms in the home, as such inquiries are essential to a comprehensive safety assessment.

This is a Policy Statement of the American Academy of Child and Adolescent Psychiatry.
References

Source of Statistics Cited
1. *Injury Prevention*, Brief Report, 29 June 2015, Gun ownership and social gun culture, Bindu Kalesan,Marcos D Villarreal, Katherine M Keyes, Sandro Galea
7. [http://www.cdc.gov/mmwr/preview/mmwrhtml/00046149.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/00046149.htm)

For more information or to review AACAP’s Policy Statements visit [www.aacap.org](http://www.aacap.org).
ILLINOIS

CHILD AND ADOLESCENT PSYCHIATRIST
Chicago, IL

The Department of Psychiatry, Section of Child and Adolescent Psychiatry at Rush University Medical Center is seeking a full-time Child and Adolescent Psychiatrist in its outpatient Child Psychiatry Program. Qualified candidates must be board certified in Psychiatry and either BE/BC in Child and Adolescent Psychiatry. This position includes supervision of residents and child and adolescent fellows as well as direct treatment and may include an administrative role commensurate with experience. The Section of Child and Adolescent Psychiatry has a strong clinical and community-based academic program. This position entails a heightened focus on community mental health, and will also offer an excellent opportunity for clinical work, resident and fellow supervision, and an administrative role. In addition to these duties, participation in research projects, local and national organized medicine, community education, as well as academic presentations of clinical and research related work is greatly encouraged and supported.

Rush University Medical Center, located in downtown Chicago, is a national leader in academic medicine. The Department of Psychiatry has been expanding its nationally recognized and vibrant research, clinical and educational programs. Our premier academic medical center encompasses a 664-bed hospital serving adults and children. In January 2012, Rush opened a new 376-bed hospital building, known as the Tower, which is part of the Medical Center’s major renovation of its campus.

Interested applicants should forward their cover letter and CV via email to: Louis Kraus, MD
Women’s Board Professor Chief of Child and Adolescent Psychiatry
Director of AARTS Center Attention of: Kristin Hill Faculty Recruitment
Kristin_hill@rush.edu

Rush University Medical Center is an equal opportunity employer.

Company: Rush University Medical Center (947904)
Job ID: 8347177
http://jobsource.aacap.org/jobs/8347177

MASSACHUSETTS

TRAINING DIRECTOR, CHILD AND ADOLESCENT PSYCHIATRY FELLOWSHIP
Boston, MA

Boston Children’s Hospital (BCH) is seeking an energetic and innovative mid-career child and adolescent psychiatrist interested in the education and mentorship of the next generation of child and adolescent psychiatrists. This training director position will oversee a well-established, ACGME-accredited child and adolescent psychiatry fellowship program with 10 fellows along with a long-standing Harvard Medical School student rotation. BCH is the #1 ranked pediatric hospital in the nation. Affiliated with Harvard Medical School, BCH is located in the heart of an incredible academic-medical community, steps away from Harvard Medical School, adjacent to 2 of Boston’s leading hospitals as well as the Dana Farber Cancer Center. For over 60 years, the Department of Psychiatry has provided essential and highly valued mental health services to the hospital, local communities, and the Commonwealth of Massachusetts. With over 140 faculty members (42 psychiatrists and 104 psychologists), the Department’s active and diverse programs in clinical services, education, and research encompass all aspects of the field of child and adolescent behavioral health. The Department offers a wide range of clinical services with on-site outpatient, inpatient, consultation, and community programs. Clinicians in our programs assess and treat children with complex neuropsychiatric illnesses and a vast array of comorbid physical illnesses. Our patients come from Boston, the region and around the world. Yet the Department is committed to public health endeavors, with collaborative and integrated care efforts in area schools, community health centers and pediatric practices, caring for the full range of psychiatric illness in children. The Department is in the midst of growing its continuum of clinical services as well as expanding its clinical and translational research portfolio. Reflective of this breadth of experience available, the Department’s fellowship program has graduated over 300 child and adolescent psychiatrists who have gone on to successful careers in clinical, educational, administrative, advocacy, and research realms. We seek now a physician to join us in training our next generation of physicians who will work in the nation’s evolving health care system to reach children and families.

Job Requirements: Candidates must be board certified in child and adolescent psychiatry and ideally will have experience in residency and/or fellowship training. The position will include appointments at Boston Children’s Hospital and Harvard Medical School.

Company: Boston Children’s Hospital
(881542)
Job ID: 8350651
http://jobsource.aacap.org/jobs/8350651

NEBRASKA

CHILD AND ADOLESCENT PSYCHIATRIC HOSPITALIST OPPORTUNITY
Lincoln, NE

Bryan Physician Network, the employed medical group of Bryan Health, has a Child and Adolescent Psychiatric Hospitalist opportunity. Average Daily Census of 13-22 28 bed child and adolescent unit provides acute crisis stabilization for youth 3-18 Wide range of diagnoses treated The 7 days on and 7 days off schedule allows for travel and time with family that few other jobs can accommodate Dedicated team of experienced social workers and therapists, psych pharmacists and other professionals work closely with our Psychiatric Hospitalists Competitive compensation and benefits package Bryan Health is the regional leader in providing mental health services and offers 66 inpatient mental health beds, a dedicated mental health emergency department, drug and alcohol treatment facility, partial hospitalization, individual and family counseling, biofeedback, and many other outpatient services. If you...
desire to have an incredible impact on the youth in a community, this is where you want to be! About the Community

According to Forbes, Lincoln is the 7th Best Place in the country for Business and Careers! Lincoln, Nebraska has earned a reputation as one of the Midwest’s most beloved cities. Home to fine culinary and artistic treasures, a budding live music scene, breath-taking parks, numerous golf courses, miles of biking trails, and a friendly Midwestern attitude, Lincoln offers the exhilaration of a large city and the serenity of a smaller town all in one place. Suburban living offers charming family neighborhoods, top-notch public and private K-12 schools, and a cost of living 10.2% below the national average! Downtown Lincoln is a vibrant, growing “urban oasis” evidenced by the resurgence of young professionals choosing to live and play in the city. Lincoln offers something for every lifestyle!

Contact in Confidence:
Brenda McGinn
brenda.mcginn@bryanhealth.org
402-481-4526
www.bryanhealth.com/careers/physician-opportunities

Company: Bryan Health (912612)
Job ID: 8292403
http://jobsource.aacap.org/jobs/8292403

CHIEF OPERATING OFFICER AND SENIOR VICE PRESIDENT OF OPERATIONS
Omaha, NE

Scion Executive Search is conducting the search for the Chief Operating Officer and the Senior Vice President of Operations on behalf of Mosaic; an incredible nonprofit that delivers compassionate services and provides a voice to people with intellectual and developmental disabilities. Both exciting, full-time roles are based in Omaha, NE.

If you are passionate, offer deep nonprofit multi-state ID | DD operations experience, and have a desire to join a mission driven, impactful, and positive organization, this opportunity could be for you! Please visit us online at www.scionstaffing.com to review full position descriptions and apply directly.

VIRGINIA

CHILD AND ADOLESCENT PSYCHIATRIST
Shenandoah Valley

The Commonwealth Center for Children and Adolescents (CCCA) invites you to consider a Child and Adolescent Psychiatry position in the beautiful Shenandoah Valley. CCCA is Virginia’s only public acute psychiatric hospital for children and adolescents. CCCA is 48-bed hospital serves youngsters with a variety of serious psychiatric disorders from across the state of Virginia. Treatment is provided in a relationship-based, collaborative, trauma-informed treatment model of care, in which the psychiatrist is the head of the child’s treatment team on a 12-bed unit.

As Psychiatrist, you will direct a multidisciplinary treatment team multidisciplinary team consisting of a psychologist, social worker, nurse, substance abuse counselor, direct care staff, and teachers, providing treatment for children and adolescents with complex, co-morbid, and severe mental illnesses. Expertise in psychiatric evaluation and treatment, including psychopharmacology, is essential.

CCCA serves as the inpatient child psychiatry training center for the University of Virginia Department of Psychiatry and Neurobehavioral Sciences child psychiatry fellows and general psychiatry residents, and abundant education and supervision opportunities are available, including a clinical faculty appointment at the University of Virginia for eligible candidates.

For further requirements and to apply, please visit the Virginia Jobs at http://jobs.virginia.gov/. The position offers a competitive salary with full state benefits including vacation and educational conference time, retirement plan, medical and dental insurance, disability plan, life insurance, etc.

Please contact our Human Resource office at (540) 332-2116 for further questions. CCCA is an equal opportunity, affirmative action employer.

The Department of Psychiatry at the University of Colorado School of Medicine, the Division of Child and Adolescent Psychiatry, and the Pediatric Mental Health Institute (PMHI) at Children’s Hospital Colorado invites applications for Child and Adolescent Psychiatrist faculty positions. With an ambitious strategic plan, the PMHI is actively recruiting for several Child and Adolescent Psychiatrists each year. Qualified applicants must demonstrate clinical experience and excellence with children and adolescents and the ability to manage different levels of acuity. Services include inpatient and partial hospitalization settings, outpatient and day treatment clinics, Psychiatric Emergency Department, and Consultation and Liaison services. With active training programs, applicants must demonstrate the ability to apply and implement evidence based approaches to care and a desire to work with trainees and milieu staff. Applicants must possess a Colorado Medical License, DEA Certificate, Board Certified in Psychiatry, Board eligible in Child Psychiatry, and must obtain privileges through Children’s Hospital Colorado. For more information please contact Melissa Sinclair (Melissa.Sinclair@ucdenver.edu) or apply online at www.cu.edu/careers. Please reference job posting numbers 03366 and 02789.
Ready to go, from hour 1 to hour 12
Once-daily Aptensio XR starts working by hour 1 and controls ADHD symptoms until hour 12.³

Aptensio XR (methylphenidate HCl extended-release) demonstrated statistical significance at all time points tested post dose: 1, 2, 3, 4.5, 6, 7.5, 9, 10.5, and 12 hours.¹

Proven efficacy
Aptensio XR delivered significant results from hour 1 to hour 12 in a phase III trial (P<0.0261) with children aged 6 to 12 years (N=26).¹²
Aptensio XR significantly improved symptoms within 1 week of treatment in a second phase III trial with children and adolescents aged 6 to 17 years (N=221).³

Designed to peak twice a day
Aptensio XR delivers ~40% of methylphenidate as immediate-release and ~60% as extended-release¹
Methylphenidate concentration reaches an initial peak at approximately 2 hours after dosing and a second peak at approximately 8 hours after dosing¹

Low discontinuation rates
No patients discontinued due to adverse events during the double-blind phase of Study ¹
Two patients, 4.4% of the patients taking 40 mg of Aptensio XR in the double-blind phase of Study 2, discontinued due to insomnia, nausea, and/or rapid heart rate³

Seven dosage strengths
Aptensio XR comes in 10, 15, 20, 30, 40, 50, and 60 mg doses for individualized treatment³
Aptensio XR may be taken whole, or the capsule may be opened and the entire contents sprinkled onto applesauce.¹

Visit booth #2215 at AACAP to learn more

INDICATION
Aptensio XR (methylphenidate HCl extended-release) is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE AND DEPENDENCE
CNS stimulants, including Aptensio XR, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

Please see full Important Safety Information on next page.
Please see Brief Summary of Prescribing Information, including Boxed Warning, on pages immediately following full Important Safety Information.
INDICATION
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CNS stimulants, including Aptensio XR, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

- Aptensio XR is contraindicated:
  - In patients known to be hypersensitive to methylphenidate or other components of Aptensio XR. Hypersensitivity reactions, such as angioedema and anaphylactic reactions, have been reported.
  - During treatment with monoamine oxidase inhibitors (MAOIs) and within 14 days following discontinuation of treatment with an MAOI because of the risk of hypertensive crisis.
- Prior to treating pediatric patients and adults with CNS stimulants including Aptensio XR, assess for the presence of cardiac disease (i.e., perform a careful history, family history of sudden death or ventricular arrhythmia, and physical exam). Educate patients about abuse, monitor for signs of abuse and overdose, and periodically reevaluate the need for Aptensio XR use.
- Sudden death, stroke, and myocardial infarction have occurred in adults treated with CNS stimulants at recommended doses. Sudden death has occurred in children and adolescents with structural cardiac abnormalities and other serious cardiac problems, as well as in adults taking CNS stimulants at recommended doses for ADHD. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious cardiac arrhythmias, coronary artery disease, or other serious cardiac problems. Further evaluate patients who develop exertional chest pain, unexplained syncope, or arrhythmias during Aptensio XR treatment.
- CNS stimulants cause an increase in blood pressure (mean increase approximately 2 to 4 mm Hg) and heart rate (mean increase approximately 3 to 6 bpm). Individuals may have larger increases. Monitor all patients for hypertension and tachycardia.
- Exacerbation of preexisting psychosis: CNS stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a preexisting psychotic disorder.
- Induction of a manic episode in patients with bipolar disorder: Prior to initiating treatment, screen patients for risk factors for developing a manic episode (e.g., comorbid or history of depressive symptoms or a family history of suicide, bipolar disorder, or depression).
- New psychotic or manic symptoms: CNS stimulants, at recommended doses, may cause psychotic or manic symptoms (e.g., hallucinations, delusional thinking, or mania) in patients without a prior history of psychotic illness or mania.
- Cases of painful and prolonged penile erections and priapism have been reported with methylphenidate products. Immediate medical attention should be sought if signs or symptoms of prolonged penile erections or priapism are observed.
- Patients who are not growing or gaining height or weight as expected may need to have their treatment interrupted.
- Stimulants used to treat ADHD are associated with peripheral vasculopathy, including Raynaud’s phenomenon. Signs and symptoms are usually intermittent and mild; however, very rare sequelae include digital ulceration and/or soft tissue breakdown. Careful observation for digital changes is necessary during treatment with ADHD stimulants.
- CNS stimulants have been associated with weight loss and slowing of growth rate in pediatric patients. Closely monitor growth (weight and height) in pediatric patients treated with CNS stimulants, including Aptensio XR.
- Based on accumulated data from other methylphenidate products, the most common (>2% and twice the rate of placebo) adverse reactions are decreased appetite, decreased weight, nausea, abdominal pain, dyspepsia, dry mouth, vomiting, insomnia, anxiety, nervousness, restlessness, affect lability, agitation, irritability, dizziness, vertigo, tremor, blurred vision, increased blood pressure, increased heart rate, tachycardia, palpitations, hyperhidrosis, and pyrexia. There is limited experience with Aptensio XR in US double-blind, placebo-controlled trials. Because of very different study designs, adverse events following Aptensio XR treatment were not merged between studies. Adverse events following treatment with placebo were, however, merged. At least 5% of patients in any treatment group reported abdominal pain (combined preferred terms abdominal pain and abdominal pain upper), decreased appetite, headache, and insomnia.
- The long-term efficacy of methylphenidate in pediatric patients has not been established. The safety and effectiveness of Aptensio XR in pediatric patients under 6 years have not been evaluated.
- Limited published studies report on the use of methylphenidate in pregnant women; however, the data are insufficient to inform any drug associated risks. The background risk of major birth defects and miscarriage for the indicated population are unknown.
- Patients should be advised to tell their physicians if they are pregnant or plan to become pregnant. It is not known if Aptensio XR will harm their unborn baby.
- Nursing mothers should be advised to discontinue drug or discontinue nursing, taking into consideration the importance of the drug to the mother because methylphenidate is present in human milk.

ADH-9-00052-3

Please see Brief Summary of Prescribing Information, including Boxed Warning, on next pages.

APTENSO XR® (methylphenidate HCl extended-release) for oral use, CII Rx only

**BRIEF SUMMARY:** Consult Full Prescribing Information for Complete Product Information

**WARNING: ABUSE AND DEPENDENCE**

CNS stimulants, including APTENSO XR, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing, and monitor for signs of abuse and dependence while on therapy.

**INDICATIONS AND USAGE**

APTENSO XR is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

**CONTRAINDICATIONS**

Hypersensitivity to methylphenidate or other components of the product. Hypersensitivity reactions such as angioedema and anaphylactic reactions have been reported in patients treated with methylphenidate products.

Concomitant treatment with monoamine oxidase inhibitors, and also within 14 days following discontinuation of treatment with a monoamine oxidase inhibitor, because of the risk of hypertensive crisis.

**WARNINGS AND PRECAUTIONS**

Potential for Abuse and Dependence CNS stimulants, including APTENSO XR, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing, and monitor for signs of abuse and dependence while on therapy.

**Serious Cardiovascular Events**

Sudden death, stroke, and myocardial infarction have been reported in adults with CNS stimulant treatment at recommended doses. Sudden death has been reported in pediatric patients with structural cardiac abnormalities, cardiomyopathies, or serious heart problems taking methylphenidate stimulants at recommended doses for ADHD. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious heart arrhythmia, coronary artery disease, and other serious heart problems. Further evaluate patients who develop exertional chest pain, unexplained syncope, or arrhythmias during APTENSO XR treatment.

**Blood Pressure and Heart Rate Increases**

CNS stimulants cause an increase in blood pressure (mean increase approximately 2 to 4 mm Hg) and heart rate (mean increase approximately 3 to 6 bpm). Individuals may have larger increases.

Monitor all patients for hypertension and tachycardia.

**Psychiatric Adverse Reactions**

Exacerbation of Pre-Existing Psychosis CNS stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychotic disorder. Induction of a Manic Episode in Patients with Bipolar Disorder CNS stimulants may induce a manic or mixed episode in patients. Prior to initiating treatment, screen patients for risk factors for developing a manic episode (e.g., comorbid or history of depressive symptoms or a family history of suicide, bipolar disorder, or depression).

**Neuropsychiatric Events**

APTENSO XR, like other methylphenidate products, may cause psychotic or manic symptoms (e.g., hallucinations, delusional thinking, or mania) in patients without a prior history of psychiatric illness or mania. If such symptoms occur, consider discontinuing APTENSO XR. In a pooled analysis of multiple short-term, placebo-controlled studies of CNS stimulants, psychotic or manic symptoms occurred in approximately 0.1% of CNS stimulant-treated patients, compared to 0.0% in placebo-treated patients.

**Priapism**

Prolonged and painful erections, sometimes requiring surgical intervention, have been reported with methylphenidate products, in both pediatric and adult patients. Priapism was not reported with drug initiation but developed after some time on the drug, often subsequent to an increase in dose. Priapism has also appeared during a period of drug withdrawal (drug holidays or during discontinuation). Patients who develop abnormally sustained or frequent and painful erections should seek immediate medical attention.

**Peripheral Vasculopathy**

including Raynaud's Phenomenon Stimulants, including APTENSO XR, used to treat ADHD are associated with peripheral vasculopathy, including Raynaud's phenomenon. Signs and symptoms are usually intermittent and mild; however, very rare sequelae include digital ulceration and/or soft tissue breakdown. Effects of peripheral vasculopathy, including Raynaud's phenomenon, were observed in post-marketing reports at different times and at therapeutic doses in all age groups throughout the course of treatment. Signs and symptoms generally improve after reduction in dose or discontinuation of drug. Careful observation for digital changes is necessary during treatment with ADHD stimulants. Further clinical evaluation (e.g., rheumatology referral) may be appropriate for certain patients.

**Long-Term Suppression of Growth**

CNS stimulants have been associated with weight loss and slowing of growth rate in pediatric patients. Closely monitor growth (weight and height) in pediatric patients treated with CNS stimulants, including APTENSO XR. Careful follow-up of weight and height in pediatric patients aged 10 to 17 years who were randomized to other methylphenidate or non-medication treatment groups over 14 months, as well as in naturalistic subgroups of newly methylphenidate-treated and non-medication treated pediatric patients over 36 months (to the ages of 10 to 13 years), suggests that consistently medicated pediatric patients (i.e., treatment for 7 days per week throughout the year) have a temporary slowing in growth rate (on average, a total of about 2 cm less growth in height and 2.7 kg less growth in weight over 3 years), without evidence of growth rebound during this period of development. Published data are inadequate to determine whether chronic use of amphetamines may cause a similar suppression of growth, however, it is anticipated that they likely have this effect as well. Therefore, growth should be monitored during treatment with stimulants, and patients who are not growing or gaining height or weight as expected may need to have their treatment interrupted.

**ADVERSE REACTIONS**

**Clinical Trial Experience**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. Clinical Trial Experience with Other Methylphenidate Products in Children, Adolescents, and Adults with ADHD Commonly reported (>2% of the methylphenidate group and at least twice the rate of the placebo group) adverse reactions from placebo-controlled trials of methylphenidate products include: decreased appetite, decreased weight, nausea, abdominal pain, dyspepsia, dry mouth, vomiting, insomnia, anxiety, nervousness, restlessness, affect lability, agitation, irritability, dizziness, vertigo, tremor, blurred vision, increased blood pressure, increased heart rate, tachycardia, palpitations, hyper tension, and pyrosis. Clinical Trials Experience with APTENSO XR in Pediatric Patients with ADHD The safety data in this section is based on data from two one-week controlled clinical studies of APTENSO XR in pediatric patients with ADHD, one in children ages 6 to 12 years (RP-BP-EF001, hereafter "Study 1") and one in children and adolescents ages 6 to 17 years (RP-BP-EF002, hereafter "Study 2"). Two APTENSO XR clinical studies evaluated a total of 255 patients with ADHD. Two hundred and forty-three (243) patients participated in the double-blind phase of these two clinical studies. Study 1 was a randomized, double-blind, single center, placebo-controlled, flexible-dose, cross-over study to evaluate the time of onset, duration of efficacy, tolerability and safety of APTENSO XR 15 mg, 20 mg, 30 mg, or 40 mg administered for one week in 26 pediatric patients aged 6 to 12 years who met DSM-IV criteria for ADHD. Most Common Adverse Reactions (incidence of ≥5% and at a rate at least twice placebo): abdominal pain, pyrexia and headache. Adverse Reactions Leading to Discontinuation: No subjects discontinued due to adverse reactions during the double-blind phase of this study. Study 2 was a randomized, double-blind, multicenter, placebo-controlled, parallel group, fixed-dose study of 10 mg, 15 mg, 20 mg, and 40 mg of APTENSO XR administered for one week in 221 pediatric patients (6 to 17 years of age) who met DSM-IV criteria for ADHD. Most Common Adverse Reactions (incidence of ≥5% and at a rate at least twice placebo): abdominal pain, decreased appetite, headache and insomnia. Adverse Reactions Leading to Discontinuation: Two patients (4.4%) in the APTENSO XR 40 mg group discontinued due to insomnia, nausea and rapid heart rate, respectively during the double-blind phase of the study.

**Table 1: Common Adverse Reactions Occurring in ≥2% of Pediatric Patients (6 to 17 years of age) with ADHD Taking APTENSO XR and at a Rate Greater than Placebo (Study 2)**

<table>
<thead>
<tr>
<th>Symptom Organ Class</th>
<th>APTENSO XR (n=133)</th>
<th>Placebo (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous System Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>10.9%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>9.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>2.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain upper</td>
<td>8.2%</td>
<td>0%</td>
</tr>
<tr>
<td>Nausea</td>
<td>3.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>3.8%</td>
<td>0%</td>
</tr>
<tr>
<td>Metabolism and Nutritional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased Appetite</td>
<td>4.9%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Postmarketing Experience**

The following adverse reactions have been identified during post-approval use of methylphenidate products. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These adverse reactions are as follows:

**Blood and Lymphatic System Disorders:** Pancytopenia, Thrombocytopenia, Thrombocytopenic purpura

**Cardiac Disorders:** Angina pectoris, Bradydcardia, Extrasystole, Supraventricular tachycardia, Ventricular extrasystole

**Eye Disorders:** Diplopia, Mydriasis, Visual impairment

**General Disorders:** Chest pain, Chest discomfort, Hypertrophy
**Immune System Disorders:** Hypersensitivity reactions such as Angioedema, Anaphylactic reactions, Auricular swelling, Bullous conditions, Extolitative conditions, Urticaria, Pruritus NEC, Rashes, Eruptions, and Urticariform NEC (rashes), Acute nephritis, Increased urinary protein, increased hepatic enzyme increased, Platelet count decreased. White blood cell count abnormal. Musculoskeletal, Connective Tissue and Bone Disorders: Arthralgia, Myalgia, Muscle twitching, Rhabdomyolysis.

**Nervous System Disorders:** Convulsion, Grand mal convulsion, Dyskinesia Psychiatric Disorders: Disorientation, Libido changes.

**Skin and Subcutaneous Tissue Disorders:** Alopecia, Erythema.

**DRUG INTERACTIONS**

Clinical Importantly Interactions with APTENSIO XR Monoamine Oxidase Inhibitors (MAOIs) Do not administer APTENSIO XR concomitantly or within 14 days after discontinuing MAOI treatment. Concomitant use of MAOIs and CNS stimulants can cause hypertensive crisis. Potential outcomes include death, stroke, myocardiad infarction, arterial dissection, ophthalmological complications, eclampsia, pulmonary edema, and renal failure.

**USE IN SPECIFIC POPULATIONS**

**Pregnancy Risk Summary** Limited published studies report on the use of methylphenidate in pregnant women; however, the data are insufficient to inform any drug-associated risks. No teratogenic effects were observed in embryo-fetal development studies with oral administration of methylphenidate to rats and rabbits during organogenesis at doses of 2 and 11 times, respectively, the maximum recommended human dose (MRHD). However, spina bifida was observed in rabbits at a dose of 40 times the MRHD. A decrease in pup body weight was observed in a pre- and postnatal development study with oral administration of methylphenidate to rats throughout pregnancy and lactation at doses 4 times the MRHD. The background risk of major birth defects and miscarriage for the indicated population is unknown. However, the background risk in the U.S. general population of major birth defects is 2% to 4% and of miscarriage is 15% to 20% of clinically recognized pregnancies.

**Clinical Considerations** Fetal/Neonatal adverse reactions CNS stimulants, such as APTENSIO XR, can cause vasosconstriction and thereby decrease placental perfusion. No fetal or neonatal adverse reactions have been reported with the use of therapeutic doses of methylphenidate during pregnancy; however, prolonged exposure and low birth weight infants have been reported in amphetamine-dependent mothers. Data Animal Data In studies conducted in rabbits and rats, methylphenidate was administered orally at doses of up to 75 and 200 mg/kg/day, respectively, during the period of organogenesis. Teratogenic effects (increased incidence of fetal spina bifida) were observed in rabbits at the highest dose, which is approximately 40 times the maximum recommended human dose (MRHD) on a mg/m² basis. The no effect level for embryo-fetal development in rabbits was 60 mg/kg/day (11 times the MRHD on a mg/m² basis). There was no evidence of specific teratogenic activity in rats, although increased incidences of fetal skeletal variations were seen at the highest dose (75 times the MRHD on a mg/m² basis), which is also maternally toxic. The no effect level for embryo-fetal development in rats was 25 mg/kg/day (2 times the MRHD on a mg/m² basis). When methylphenidate was administered to rats throughout pregnancy and lactation at doses of up to 45 mg/kg/day, offspring body weight gain was decreased at the highest dose (4 times the MRHD on a mg/m² basis), but other effects on postnatal development were observed. The no effect level for pre- and postnatal development in rats was 15 mg/kg/day (equal to the MRHD on a mg/m² basis).

**Lactation Risk Summary** Limited published literature, based on breast milk sampling from five mothers, reports that methylphenidate is present in human milk, which resulted in infant doses of 0.16% to 0.7% of the maternal weight-adjusted dosage and a milk/plasma ratio ranging between 1.1 and 2.7. There are no reports of adverse effects on the breastfed infant and no effects on milk production. However, long-term neurodevelopmental effects on infants from stimulant exposure are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for APTENSIO XR. The potential adverse effects on the breastfed infant from APTENSIO XR or from the underlying maternal condition. Clinical Considerations Monitor breastfeeding infants for adverse reactions, such as agitation, anorexia, and reduced weight gain.

**Pediatric Use** The safety and effectiveness of APTENSIO XR in pediatric patients under six years have not been evaluated. The safety and effectiveness of APTENSIO XR have been established in pediatric patients ages 6 to 17 years in two adequate and well-controlled clinical. The long-term efficacy of methylphenidate in pediatric patients has not been established. Long Term Suppression of Growth Growth should be monitored during treatment with stimulants, including APTENSIO XR. Pediatric patients who are not growing or gaining weight as expected may need to have their treatment interrupted. Juvenile Animal Data Rats treated with methylphenidate early in the postnatal period through sexual maturation demonstrated a decrease in spontaneous locomotor activity in adulthood. A deficit in acquisition of a specific learning task was observed in females only. The doses at which these findings were observed are at least 6 times the maximum recommended human dose (MRHD) on a mg/m² basis. In the study conducted in young rats, methylphenidate was administered orally at doses of up to 100 mg/kg/day for 9 weeks, starting early in the postnatal period (postnatal day 7) and continuing through sexual maturity (postnatal week 10). When these animals were tested as adults (postnatal weeks 13-14), decreased spontaneous locomotor activity was abnormal in males and females previously treated with 50 mg/kg/day (approximately 6 times the maximum recommended human dose [MRHD] on a mg/m² basis) or greater, and a deficit in the acquisition of a specific learning task was observed in females exposed to the highest dose (12 times the MRHD on a mg/m² basis).

The no effect level for juvenile neurobehavioral development in rats was 5 mg/kg/day (half the MRHD on a mg/m² basis). The clinical significance of the long-term behavioral effects observed in rats is unknown.

**Geriatric Use** Clinical trials of APTENSIO XR did not include any patients aged 65 years and over. In general, dose selection for an elderly patient start at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy.

**DRUG ABUSE AND DEPENDENCE**

Controlled Substance APTENSIO XR contains methylphenidate a Schedule II controlled substance.

Abuse CNS stimulants including APTENSIO XR, other methylphenidate-containing products, and amphetamines are a high potential for abuse. Abuse is characterized by impaired control over drug use despite social, economic, and criminal problems, may include the use of the same or other illegal or controlled substances, may commit a criminal activity to support the abuse, may have a decreased interest in previous hobbies and interests, and may display tolerance or withdrawal. Signs and symptoms of CNS stimulant abuse include increased heart rate, respiratory rate, blood pressure, and/or weight, dilated pupils, hyperactivity, restlessness, insomnia, decreased appetite, loss of coordination, tremors, flushed skin, and excitement. Symptoms of acute and chronic abuse include abdominal pain, Anxiety, psychosis, hostility, aggression, suicidal or homicidal ideation have also been observed. Abusers of CNS stimulants may chew, snort, inject, or use other unapproved routes of administration which can result in overdose and death. To reduce the abuse of CNS stimulants including APTENSIO XR, assess the risk of abuse prior to prescribing. After prescribing, keep careful prescription records, educate patients and their families about abuse and on proper storage and disposal of CNS stimulants, monitor for signs of abuse while on therapy, and re-evaluate the need for APTENSIO XR use.

**Dependence Tolerance Tolerance** (a state of adaptation in which exposure to a drug results in a reduction of the drug’s desired and/or undesired effects over time) can occur through chronic treatment with CNS stimulants including APTENSIO XR. Dependence Physical dependence (a state of adaptation manifested by a withdrawal syndrome produced by abrupt cessation, rapid dose reduction, or administration of an antagonist) can occur in patients treated with CNS stimulants including APTENSIO XR. Withdrawal symptoms may occur following prolonged high-dose administration of CNS stimulants include extreme fatigue and depression.

**OVERDOSAGE**

**Signs and Symptoms** Signs and symptoms of acute methylphenidate overdose, resulting principally from overstimulation of the CNS and from excessive sympathomimetic effects, may include the following: nausea, vomiting, diarrhea, restlessness, anxiety, agitation, tremors, hyperreflexia, muscle twitching, convulsions (may be followed by coma), euphoria, confusion, hallucinations, delirium, sweating, flushing, headache, hyperpyrexia, tachycardia, palpitations, cardiac arrhythmias, hypotension, hypotension, tachycardia, mydriasis, dryness of mucus membranes, and rhabdomyolysis.

**Management of Overdose** Consult with a Certified Poison Control Center (1-800-222-1222) for up-to-date guidance and advice on the management of overdosage with methylphenidate. Provide supportive care, including close medical supervision and monitoring. Treatment should consist of those general measures employed in the management of overdosage with any drug. Consider the possibility of multiple drug overdosage. Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. Use supportive and symptomatic measures.

Gastric contents may be evacuated by gastric lavage as indicated. Before performing gastric lavage, control agitation and seizures if present and protect the airway. Other measures to detoxify the gut include administration of activated charcoal and a cathartic. Intensive care must be provided to maintain adequate circulation and respiratory exchange; external cooling procedures may be required for pyrexia.

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