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Call for Papers Deadline: February 15, 2017
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64TH ANNUAL MEETING
OCTOBER 23–28, 2017
WASHINGTON, DC

Marriott Wardman Park & Omni Shoreham Hotels
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Cover Photo: Patrick Kennedy, Kana Enomoto, Assistant Secretary, SAMHSA, and Gregory K. Fritz, MD, President, AACAP, working together and getting ready for the Karl Menninger, MD, Plenary.
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

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The mission of AACAP News includes:
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3. Recording the history of AACAP.
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Integrated Care & integratedcareforkids.org

I am incredibly pleased with the direction and efforts shown by members and staff regarding my Presidential Initiative on Integrated Care. We feel certain that the rationale for integrated care rests on a firm foundation. Lack of access to needed mental health care, decreased stigma and greater awareness of the importance of psychological issues in medical care, recognition that our hugely expensive medical system does not work well, and the importance of prevention and early intervention are the forces behind the movement toward integrated care, and none of these forces are about to go away – no matter what happens with healthcare.

AACAP interest in integrated care at all levels was best reflected in the vibrant program at our recent Annual Meeting in New York City. A myriad of presentations focused on one aspect or another of integrated care. In addition to the meeting, Tami Benton, MD, and Gary Maslow, MD, MPH, are making great progress on editing the volume of Child and Adolescent Psychiatric Clinics of North America, devoted completely to pediatric integrated care, which is scheduled to come out this fall. In the training realm, several AACAP committees are working to describe the competencies that child and adolescent psychiatrists need to be effective in the integrated care world.

Perhaps the most exciting news relating to AACAP’s involvement in integrated care is the online Resource Center that went live at our meeting in October. Available at integratedcareforkids.org, the website is the work of David DeMaso, MD, Heather Walter, MD, and the AACAP IT staff (led by Paul Hou and Don Kenneally). It contains a wealth of information available at the click of a mouse, including an exhaustive bibliography (with links to the actual articles), hard-to-find “white papers” on integrated care from various organizations, educational materials, outcomes and evaluation instruments, and a section where individuals can describe their own integrated care projects. This section is still being populated with reports, and members are encouraged to contribute their own experiences (the process takes 10-15 minutes to upload the relevant information).

I strongly encourage all of you to take the time and check out integratedcareforkids.org. I welcome all your feedback. In addition, I look forward to learning the other innovative ways my fellow members are moving towards the future of integrated care.

Gregory K. Fritz, MD
President, AACAP
Evolution of Pediatric Psychosomatic Medicine – Yesterday and Today

David R. DeMaso, MD, and Richard J. Shaw, MD

Yesterday

In their landmark editorial, Steiner and his colleagues (1993) summarized the status of the field of what was then known as Consultation-Liaison Psychiatry (CLP). Major issues that were cited as an impediment to progress included the lack of a firm patient base, precarious funding, and low rates of reimbursement. The small number of individuals active in the specialty, a lack of mentorship, and insufficient Department/Division support were highlighted. Despite the formation of the AACAP Committee on the Physically Ill Child to create a national forum for research development, the lack of research funding was described as an important limitation. On a more optimistic note, Knapp and Harris (1998) were the two 10-year reviews of the clinical findings and research approaches in CLP. In their reviews, they noted that despite the advent of managed care, CLP was flourishing and drew attention to the opportunity for the innovative application and extensive deployment of the special skills of the child and adolescent psychiatrist.

In the first U.S. survey of CLP practice patterns, Shaw et al. (2006) drew attention to the market forces in health care that were creating ever-increasing pressures to control costs with the effect that funding of many CLP programs seemed in jeopardy and many national programs reported a decrease in financial support. Financial concerns and lack of staffing were identified as major concerns. It was also evident from survey responses that the demand for expert psychiatric consultation in the pediatric setting was growing rapidly and few services cited the “lack of a firm patient base” previously described by Steiner et al. (1993) as a significant concern. Increases in medical acuity were proposed as one reason for the growing demand for CLP services along with growing recognition on the part of pediatricians about the impact of the ‘New Morbidity’ – behavioral, developmental, and social functioning problems encountered in their practices (American Academy of Pediatrics, 1993, 2001). Echoing Knapp and Harris (1998), Shaw and colleagues (2006) commented on the applicability of the skill set of the consultation-liaison psychiatrist in the era of managed care, with their focus on consultation, differential diagnosis, psychopharmacology, and short-term therapy. The survey highlighted the potential role for CLP to provide outpatient care in the pediatric setting as part of the continuum of care.

Today

It is apparent today that much has changed in CLP or Pediatric Psychosomatic Medicine (PPM) as it has been renamed. In a new U.S. survey (Shaw et al., 2016), a dramatic increase in the amount of research, now funded by multiple National Institutes of Health and other agencies, has helped establish the strong economic benefits of psychiatric consultation in the pediatric setting, a fact long recognized by primary and specialty care pediatric practitioners. It is evident that PPM is taking an ever increasingly important position within academic medical centers. The demand for child psychiatric consultation has continued to grow and with it an increased awareness on the part of hospitals regarding the value and necessity of a strong child psychaitric consultation service. Mandates for routine psychiatric consultation for specific patient populations, for example, solid organ and stem cell transplant patients, or depression screening in patients with cystic fibrosis, have in part driven this process. However, increased competition for patients along with national ratings has encouraged many hospital enterprises to fund behavioral health services with the goal of improving market share by providing integrated behavioral health care services. The prior focus on sustainability of services based on professional billings, something never considered a viable option, now seems to play a less important role in hospital budgets as population management approaches are embraced by hospital systems. Increasingly, PPM services are viewed as an “essential or mission critical service” and ones that require specific lines of funding when new centers for clinical excellence are developed. Programs across North
America have reported a steady increase in financial support for psychiatric consultation, along with increases in levels of staffing. Departments of Psychiatry have increasingly recognized the value of providing strong PPM services leading some to spin off additional hospital funding for training programs in child and adolescent psychiatry.

**Tomorrow?**

As medical directors of PPM services, it is readily apparent that the specialty of PPM is in the midst of an exciting phase of expansion and growth. Rarely a week goes by without an email advertising another unfilled vacancy for a PPM psychiatrist. The AACAP Committee on the Physically Ill Child is packed to capacity with attendees at every AACAP Annual Meeting. The work of this committee has resulted in a diverse and highly-rated selection of symposia at the Annual Scientific Meetings in addition to a listserv that has become a lively forum for the discussion of important clinical questions and dilemmas. Pediatric hospitals are grappling with some of the most challenging psychiatric issues of our time. These include new clinical populations, for example patients with POTS, pediatric autoimmune neuropsychiatric syndrome (PANS), and autoimmune encephalitis, as well as social and service dilemmas, resulting in the tremendous increase in numbers of pediatric hospitalization of psychiatric medical boarders and the overburdening of emergency room boarding, which has spawned a new AACAP Committee on Emergency Child Psychiatry.

However, in looking more closely, there may be other important factors to consider in the success of PPM. The first relates to the nature of the patient population. Routinely, trainees at all levels comment on the richness of their clinical experiences during their PPM rotations. It is a specialty that allows the child and adolescent psychiatrist to remain firmly rooted within the practice of clinical medicine while grappling with some of the most fascinating and complex dilemmas of our time, e.g., autoimmune encephalitis of unknown etiology refractory to treatment. The decision of the American Board of Psychiatry and Neurology to discontinue the section of the Child and Adolescent Psychiatry Board Certification formerly dedicated to CLP notwithstanding, PPM remains a viable and exciting career choice for new graduates. Triple board training programs have provided an important portal of entry for physicians with an interest in this field. Second, much of PPM’s success derives from its ability to partner with the pediatric community in the provision of integrated behavioral health care. PPM programs that have taken the risk of reaching out and providing embedded point of care services within the pediatric subspecialty clinics have seen rich rewards in terms of expanding clinical services and collaborative research. Pain services, in particular, have been fertile ground for exactly this type of integrated care and we are now witnessing the re-emergence of the multidisciplinary day treatment program, focusing on the rehabilitative treatment of patients with comorbid physical and psychiatric issues at medical centers across North America.

Knapp and Harris’ (1998) comment that the “child psychiatrist’s training and skill in the integration of biological, pharmacological, developmental, intrapsychic, and family assessment are more valuable than ever” has proven itself to be prescient. And while the importance of the specialty was something that its practitioners have never doubted, it is satisfying in 2016 to see PPM so thoroughly in the mainstream of child and adolescent psychiatry.

**References**


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What is a Chemical Restraint? How Should it be Managed?

Please look at these two case examples in light of the discussion that follows.

Case One: John is a 16-year-old adolescent inpatient with a history of bipolar disorder. He becomes highly agitated and threatening in a conflict with a peer. The psychiatrist decides to give him an additional dose of Seroquel (100 mg). John is resistant to taking the medication at first and then grabs and swallows it. In 15 minutes, he goes to sleep in his room.

Question: Is this a Chemical Restraint?

Case Two: Sandra is a 14-year-old teenager with a history of agitation, mood disorder, and self-harm issues, who attacks a staff member over a visitation refusal. She is restrained and an intramuscular dose of Geodon 20 mg ordered by the attending psychiatrist is administered. After the injection, she is guided to the open observation room, where in five minutes she falls asleep.

Question: What type of restraint is described?

Brief Historical Background

Chemical restraint might be considered by patients to be a more invasive intervention than its physical counterpart, because it is a direct drug effect on the brain, eliciting the fear of “Mind Control” suggested in “One Flew Over the Cuckoo’s Nest.”

Chemical restraint might be considered by patients to be a more invasive intervention than its physical counterpart, because it is a direct drug effect on the brain, eliciting the fear of “Mind Control” suggested in “One Flew Over the Cuckoo’s Nest.”

Over the years, “medication for behavioral control” has become a preferred alternative, perhaps, because it more accurately describes its purpose.

The consumer movement of the 1970s that helped drive de-institutionalization of those with mental illness, as well as the recent reform of restraint regulations, support the rights of patients to be free of unwanted psychological intrusions unless they present an immediate physical danger to themselves or others. Curiously, most of the restraint literature since 2000 has stressed changes in policies dealing with physical rather than chemical restraint. In fact, the report of 140 deaths due to restraint over a 10-year period in the Hartford Courant that galvanized public, legislative, and regulatory opinion against restraint and seclusion use did not include deaths related to chemical restraints (Weiss 1998). Maybe this reflects the difficulties that non-psychiatric professionals had in assessing what was an appropriate medication, dose, and route to use for treatment with an agitated patient.

To address this issue, in 1999, in its initial rule, and, in 2006, in the final rule, the Center for Medicare and Medicaid Services (CMS), provided a regulatory review and explanation of chemical restraint, that it then used in its facility surveys, and which were also adopted by State agencies and the Joint Commission. The CMS definition is:

A RESTRAINT IS A DRUG OR MEDICATION WHICH IS USED AS A RESTRICTION TO MANAGE THE PATIENT’S BEHAVIOR OR RESTRICT THE PATIENT’S FREEDOM OF MOVEMENT AND IS NOT A STANDARD TREATMENT OR DOSAGE FOR THE PATIENT’S CONDITION (Federal Register, B).

Standard treatments enable patients to participate in their living environment. Sedation is evidence of chemical restraint, because it removes the patient from interpersonal interactions (Federal Register Rules and Regulations 2006).

Over the years, psychiatric treatment facilities have developed their own interpretations of chemical restraint. Some examples that I have heard include:

- A chemical restraint occurs only if intramuscular medications are used.
- A chemical restraint occurs only if a medication is used that is not on the patient’s current medication list
- A chemical restraint occurs only if it is not included in a PRN (pro re nata = as the occasion may arise) protocol.
- A chemical restraint is when an agent is used to control a patient’s behavior (Currier 2000).

In light of the CMS definition, however, these interpretations would appear to be in error, because they focus on the ordering of medication, rather than its effect on the patient’s freedom to participate in activities.
Looking at the Case Examples

Case One meets the CMS criteria for chemical restraint because the medication dose put the patient to sleep. As a result, John could not participate in daily activities. However, when he awakens, he can resume them. When that happens, he would no longer be chemically restrained.

Case Two meets the CMS criteria for two types of restraint: Sandra is placed in a physical hold, which restricts her freedom of movement (Federal Register 2006 A); then she is given an intramuscular medication which puts her to sleep (Federal Register 2006 B). For reasons previously described, it is possible that no restraint will be recorded by staff, because the medication was part of the patient’s medication therapy, and holding a patient momentarily to administer medication may not be considered by some staff, despite regulatory guidelines, to be a restraint.

Managing Chemical Restraints

In CMS accredited facilities all restraints, whether physical or chemical, require the same documentation: ordering by a licensed health care practitioner, time limits, face-to-face contact with the patient within an hour, re-ordering limits (Federal Register Rules and Regulations 2006).

In CMS facilities that are also accredited by the Joint Commission, there are similar requirements.

“All restraints whether physical or chemical require the same documentation, ordering by a licensed health care practitioner, time limited orders, in-person evaluations within an hour of application, revisions to the patient’s plan of care, the intervals for monitoring, and patient assessments and reassessments to include, but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements per hospital policy” (Personal Communication, Joint Commission, August 2016).

In addition to these measures, chemical restraints require pharmacological assessment. These include: risks of medical problems (e.g., diabetes mellitus; anti-psychotic medication side effects, such as dystonia, akathisia, and parkinsonism), and medication-specific risks, for example, anaphylactic reaction with asenapine, and bronchospasm with intranasal loxapine.

In practice, using the term ‘supplementary medication dosing’ would avoid the negative connotation of the “chemical restraint” label, but probably would result in less documentation and patient monitoring. On the other hand, a chemical restraint designation, although a pejorative term, would increase patient safety by increasing monitoring.

If the cases described above were seen as supplementary medication situations, perhaps no additional monitoring would have been provided when John went to bed, and Sandra might not have gotten vital signs or respiratory monitoring if she appeared to be ‘resting comfortably.’

In summary, the designation of “chemical restraint” would appear to be a Catch 22. On the one hand, it is a negative description of a treatment intervention, while on the other hand it would promote intense monitoring, which is a critical element of acute care.

References


Dr. Masters is a consultant at Three Rivers Behavioral Health Services Midlands Campus Residential Treatment Center and adjunct professor in the Physician’s Assistant Program at the Medical University of South Carolina; as well as in the Psychiatry Department and the Physician’s Assistant program at Wake Forest Medical School Winston-Salem, North Carolina. He may be reached at kmasters@brontosaur.org or kmaster105@gmail.com.
Self-disclosing About Self-disclosure

Michael A. Shapiro, MD

A 12-year-old boy was brought to my office by his parents to initiate psychotherapy. Since the boy’s parents got divorced last year, the boy had not wanted to stay at his father’s house. Both the mother and father were concerned about this behavior. The divorce had reportedly been contentious. The mother struck me as anxious, and the father seemed superficial and distant. I wondered if this was a concoction dreamed up by one of the parents for a pending custody or alimony battle; thus, I began my interview to assess the boy’s view of his visitation with his father with a somewhat skeptical attitude. At first glance, nothing seemed amiss as he gave superficial answers of just not wanting to move his clothes or his dog between homes and it was “a hassle.” He seemed very willing to see his father for meals, movies, and social activities, but it was too burdensome to move his things to spend one night at his father’s, only to return to his mother. I could see how this seemed reasonable to a 12-year-old. I continued to probe about his reluctance to visit his father’s home, pushing deeper, and eventually, I hit upon something.

“Because it’s his fault.” What was his father’s fault? “The divorce. He cheated on my mom, I heard them yelling.” I paused. I had not heard this information before from either parent. Was he sure? “I heard them yelling, that’s what my mom said.” Had he heard this directly from his father? “No, I haven’t talked to him about it.” Why not? “Are you kidding? No way! That would be awkward.” Did his father really have an affair? Do I have to ask each of the parents separately? Awkward indeed. I felt his confusion and frustration.

Then, I felt something else. I cannot remember a time I felt it so strongly in the moment of treating a patient. I felt the urge to self-disclose. I myself went through something very similar when my parents divorced. Luckily for me (in my opinion), I was an adult when it happened – twice this boy’s age. I was not shuttled between two homes, I did not need two sets of clothing, and I did not have to worry about bringing my dog back and forth. I was an adult, I had a car and lived in another town within driving distance of both my parents. I had control of when I saw each of my parents and for how long. But I probably felt similarly to how this young boy must be feeling. I remember feeling angry and wanting to assign blame. It would have been easier that way. I wanted to tell him that I understood his feelings and what he was going through, because I went through something similar.

“I felt very strongly that self-disclosing would have helped him. But that’s the problem with feelings.”

But of course, I did not say that. I sat there and thought about what to say next, but I was not going to self-disclose. I was always taught not to self-disclose. It could flip the parameters of the therapeutic relationship, expecting the patient to care about my feelings. Perhaps it would have been “therapy” for me! Had I disclosed, would that be too much information about me? What about neutrality and objectivity?

I encouraged him to talk more. “Why should I make an effort to visit him? It’s not my fault they got divorced, he did it.” Through some more prodding and questioning, the boy admitted to feeling that his father owed him an effort to sustain the relationship, but not the other way around. His father ruined the relationship, and it was his father’s job to mend it, not the boy’s responsibility.

What I really wanted to tell this young boy was that life is not fair and that the divorce was not his fault; but that it did not matter whose fault it was. That either he is going to choose to have a relationship with his father or he will choose to forego such a relationship. That whether or not he recognizes it, his father is making an effort to sustain a relationship with him, probably more so now than before his parents separated. That as angry as he might be, letting that anger lead to the disintegration of his relationship with his father would be devastating and something he would regret. But how do I tell him that? What if he asks me how I know all this?

My desire to self-disclose persisted. I sought supervision from several colleagues. When I explained the situation, I usually prefaced it with, “I know I should not self-disclose, but…” The advice I received was helpful in pointing out the many reasons not to self-disclose. Among those, confidentiality was not a two-way road in our relationship. What if he told his friends? All my other patients? His parents? There were sufficient ways for me to help him without self-disclosing. But I did feel very strongly that it would greatly help him if I were to self-disclose. A recent psychotherapy teaching manual I had read (Hill et al. 1998) had discussed research on patients’ attitudes towards therapist interventions and had found that self-disclosure by a therapist was the highest rated intervention by patients! I felt very strongly that self-disclosing would have helped him. But that is the problem with feelings! To the boy, it felt right to avoid going to his father’s house, to punish his father for what the boy perceived to be the father’s sin of destroying the family. I also thought I needed to allow this boy to both acknowledge his feelings, but see past them. I had to do the same with mine.

Although, I thought it could help him, I never self-disclosed. I used
insight-oriented therapy to get the boy to admit to his anger, as well as his fear of knowing the truth with certainty. I used cognitive reframing to introduce situations where it was not easy to cast blame. I kept encouraging the boy to speak with his father, but he never did. He allowed me to talk with his father, which was somewhat helpful, but I was determined to not be the scapegoat for preventing the boy from talking directly with his father. I thought treatment was becoming stagnant, and I again considered self-disclosing. However, eventually the boy started spending more time with his father, and eventually slept over at his house for a few nights. The boy told me that talking about his feelings helped him feel less angry, and he found it easier to be with his father. Eventually, all parties agreed that the treatment goals had been achieved and therapy was terminated.

In terms of outcomes, this was a success. And yet, my lack of self-disclosure continued to gnaw at me. Why? Maybe because I lost the opportunity to know if it might have helped him. Maybe it would have helped him earlier in the process. Maybe it would have damaged my credibility. Maybe it would have opened me to a vulnerability that I did not desire. I do not know the answer to any of those questions. I do know that I was avoiding a sensitive topic of discussion, albeit for a good reason, but I continued to model for the boy the avoidance of discussing sensitive topics. I wanted him to take the chance to talk directly to his father, but I was not taking such a chance. I thought of my own countertransference. Maybe I was pushing him to do something I should be doing myself. Maybe it was my task to be more open with my father. Maybe I just wanted the boy to not feel alone, as I did. Maybe it would have helped me to have someone tell me they had been through it too, to validate the experience, and provide some guidance. In any case, the boy continues avoiding, as do I.

Reference

Additional Resources

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Diane K. Shrier, MD, and Adam Louis Shrier, D.Eng, JD
Asian American Student Mental Health – The “Model” Minority’s Hidden Pain

In the context of rising rates of mental health problems among teens and college students, Asian Americans stand out as struggling equally, if not more. Much of this data comes from some of this country’s most selective institutions. Thirteen of the 21 suicides at Cornell University from 1996-2006 involved Asian students. Since 2013, Asian youth accounted for 40% of the suicides at the University of Pennsylvania; and the Asian American student suicide rate at the Massachusetts Institute of Technology is quadruple the national average (Fang 2015). These numbers have been disproportionately high compared to the Asian population at these schools. At the high school level, the suicide cluster in Palo Alto, California, currently being investigated by the Center for Disease Control, included four Asian Americans among the 10 suicides; this number equals the percentage of Asian students in the school district (Rosin 2015).

However, popular press articles about teen and college mental health often fail to specify that completed suicides were of Asian heritage. It is unclear whether this oversight stems from wanting to avoid stereotyping, aiming to prevent “suicide contagion,” or from discounting contrarian views about a “model minority.” Nonetheless, the cultural backgrounds should be noted, as research suggests that the origins of depression, suicidality and completed suicide in Asian American youth may be qualitatively different. As such, mental health services and suicide prevention protocols need to be culturally tailored.

According to landmark research by counseling psychologist Joel Wong, perceived unfulfilled expectations of one’s family and self, most commonly regarding academic achievement, are often associated with suicidality among Asians in America, (Wong et al. 2011). This seeming disappointment can lead to social isolation as students feel they must “try harder” to achieve a level consonant with these beliefs. The growing pressure to avoid shame, plus the desire to bring pride to their families, can prime students to intensify their study efforts, with any apparent resulting “failure” conceptualized as a consequence of inadequacy. This heightens the sense of familial dishonor and magnifies self-blame. Students thus invest exorbitant amounts of time and energy striving for academic success; ultimately sacrificing friendships, social supports, and genuine self-esteem in the process. Their subsequent depleted emotional reserves coupled with the traditional temperamental tendency to avoid seeking help, launches the psychological free-fall.

Often, there are few detectable signs that Asian American youth are in trouble as they may continue to present well to peers, educators, and their families despite inner turmoil.

Contributing to these principles are cultural and familial values. First-generation Asian immigrants are often a highly selected group. Many came as professionals with graduate degrees to the United States in the wake of the 1965 Immigration and Naturalization Act, which sought to bolster this country’s scientific cadre during the “space race” with the then-Union of Socialist Soviet Republics, and sought to expand the physician workforce in step with the creation of Medicare and Medicaid. Others came for better opportunity; sometimes escaping poverty, persecution, or war. For many naturalized Asian Americans, getting into a top graduate school in their home countries primed their life success. As parents, they might expect their children to use the same template. Through financial sacrifice and relocation to high-achieving school districts, these parents afford their children tutoring and enrichment opportunities from a young age. Some even actively oppose efforts to reduce academic pressure, so that their children have every chance to make it to the best college possible. Once at a “prestigious” university, Asian parents may believe their young adult’s future success is assured. Currently, there is a widespread perception among Asian-American university applicants of needing entrance scores higher than a college’s average to secure admission into top-ranked schools. Likewise, the perceived “bamboo ceiling” in the workplace may reinforce the parental drive to secure advantages for their children during their high-school years (Spencer 2015; Chua 2011; Hyun 2006).

While understandable, achievement pressure from parents provides no contingency plan and no safety net. Those who succeed wildly cannot indefinitely sustain the upward trajectory. These students tend to falter in their capability to handle success by striving for more, rather than inviting contentment. Unable

“In the context of rising rates of mental health problems among teens and college students, Asian Americans stand out as struggling equally, if not more.”
Implementing contingency plans also or at least hope for these interactions. Their Asian American children expect may not have modeled these skills, but physical affection. Their own parents demonstrate more warmth using words fostering resiliency in their children, to encouraged from the vantage point of children. These parents should be coaching about raising “Americanized” a lot for their children and have high (Baumrind 1967). Asian parents who do parenting style in the United States expecting students lead to depression, family hopelessness and shame in decompen-

sities to seeking mental health care. When hopelessness and shame in decompensation students lead to depression, family stigma about failure may compound the problem and heighten suicide risk.

Developmental psychologist Diana Baumrind found “authoritative parenting,” marked by high parental expectations and high parental warmth or responsiveness, to be the optimal parenting style in the United States (Baumrind 1967). Asian parents who do a lot for their children and have high expectations, in general, may need coaching about raising “Americanized” children. These parents should be encouraged from the vantage point of fostering resiliency in their children, to demonstrate more warmth using words of appreciation, empathic listening, and physical affection. Their own parents may not have modeled these skills, but their Asian American children expect or at least hope for these interactions. Implementing contingency plans also seems necessary in case the “Plan A” of academic success does not manifest. When working with families, exploring the sustainability of happiness built on a foundation of outcompeting others can be a useful starting point, however, the risks of diminishing returns at higher levels of competition, burnout, and other mental health complications must be explicitly described. Discussing quality of life as defined by Western culture can be fruitful. Lastly, one can attempt to shift the families’ focus from academic outcomes to the importance of shaping character and good work habits to optimize long-term success.

The broad-brush picture painted above does not account for all depression and suicidality among Asian Americans, as it does not touch on the impact of biological factors, discrimination, variations in gender identity and sexual orientation, or diversity under the Asian-American umbrella. The aim is to highlight the theme of academic achievement pressure, which may contribute to the suicidal behaviors of Asian American students. Future efforts should disaggregate the data to better inform and customize mental health services and suicide prevention protocols for students of Asian heritage at all levels of secondary and tertiary education. These students need a pressure release valve, and parents and educators are best positioned to create it. Child and adolescent psychiatrists can also help through facilitating stigma reduction, improving school-wide identification of struggling students, engaging in advocacy at the legislative level, and offering culturally sensitive treatment.

References


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Should AACAP Membership Be Expanded to Include Psychologists?

Task Force on Allied Membership (TFAM)

The Task Force on Allied Membership (TFAM) is charged with evaluating, researching, and reviewing whether it makes sense for AACAP to create an allied membership category open only to psychologists. The focus of this Task Force is limited to an allied membership category for psychologists and is not a precursor for opening AACAP membership to non-physicians.

TFAM Team

Tami D. Benton, MD (chair)  
Mark S. Borer, MD  
Gabrielle “Gaye” A. Carlson, MD  
Shashank V. Joshi, MD  
David L. Kaye, MD  
Karen Dineen Wagner, MD, PhD  
Charles H. Zeanah, Jr., MD

To carry out the responsibilities of the charge, the TFAM is trying to cast as wide a net as possible, in the hopes of gathering as much information and feedback as possible on the topic from the AACAP membership. As part of this effort, the TFAM first held a Town Meeting at the recent AACAP Annual Meeting in New York. Members were encouraged to participate and share ideas, concerns, and questions regarding the topic of allowing psychologists to become members of AACAP.

In addition to the Town Hall, TFAM members, to be fair and balanced and to cover the topic's total scope, were tasked with collecting three articles for AACAP News from the membership:

- A Case Against Creating a Membership Category for Psychologists  
  Debra E. Koss, MD  
  Karen Pierce, MD
- A Case For Creating a Membership Category for Psychologists  
  Gabrielle A. Carlson, MD  
  Charles H. Zeanah, Jr., MD
- A Third Option  
  Mark S. Borer, MD

In the following pages are all three articles. Please take a moment to read and reflect on the opinions expressed in each article. As stated above, we want to hear from you. Again – we want to hear from all of you! In addition to this issue of AACAP News, the articles will be posted on AACAP’s website for future reference and feedback.

We value your opinions as AACAP members and want to be sure to take into consideration your thoughts and feelings on the matter. Please send all feedback via email to communications@aacap.org. Your comments will be compiled and used in determining and defining the ongoing conversation. Also, if you have any questions, please contact the Communications Department directly via email at communications@aacap.org or by phone at 202.966.7300, ext. 119.

The deadline to submit feedback is May 5, 2017.

Thank you – and enjoy the articles!

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2017 Catchers in the Rye Awards

Recognizing and promoting advocacy for children

The Catchers in the Rye Awards are AACAP’s most prestigious awards that recognize an AACAP member, an AACAP component, and a regional organization of the AACP Assembly for outstanding advocacy efforts. In terms of the award:

- Advocacy is any activity done by an individual AACAP member, AACAP committee, or AACAP regional organization on behalf of children and adolescents with mental health problems or for prevention efforts for children and adolescents at risk that directly benefits them or their families. For example, advocacy could include organizing mental health services for an underserved population, advocating for children and families politically, or enhancing the efforts of child and adolescent psychiatrists to provide high quality mental health services. This includes activities through the American Academy of Child and Adolescent Psychiatry.

AACAP recognizes advocacy in three categories:

- **Individual** that is an AACAP member who advocates for children
- **AACAP Component** (committee or task force) that best advocates for children
- **Regional Organization** of the AACAP Assembly whose activities best highlight the contributions of regional organizations on behalf of children.

Nominations should include a brief paragraph describing the nominee's advocacy work (only one submission per person for each category).

Nominations due by June 30, 2017

Awards will be presented at the Assembly's fall meeting and recognized at the Karl Menninger, MD, Plenary during the AACAP Annual Meeting in Washington, DC, October 2017. Please send your nominations to Megan Levy, Executive Office Manager, at mlevy@aacap.org
A Case For Creating a Membership Category for Psychologists

Gabrielle A. Carlson, MD, and Charles H. Zeanah, Jr., MD

M any of us in AACAP have worked closely with psychologists both academically and clinically. Some of us are members of interdisciplinary organizations where both specialties are included and know that the relationship has benefited both child and adolescent psychiatry and psychology. The opportunity to network and collaborate requires proximity of similar interests. We feel that the mission of AACAP to serve the mental health of children would be enriched by providing an opportunity to network formally. The Annual Meeting might be an obvious place. However, the high cost and lack of meaningful involvement for psychologists have been impediments to this opportunity.

We feel that there are some potential advantages of creating a membership category for psychologists. Expanding our membership to include psychologists could:

- Enhance our organization academically and clinically with colleagues who share our focus on children’s mental health.
- Expand AACAP’s advocacy for children’s mental health. This could strengthen our efforts to support joint initiatives and to take a stand against those that could harm the public, such as non-medical professionals prescribing pharmaceuticals for children.
- Increase the number of experts, especially in specialty areas in which we are thin because of limited numbers, thereby enhancing AACAP’s ability to inform families and professionals.
- Expand services offered and increase access by affiliating with other allied organizations and mental health professional networks.
- Increase academic collaborations, especially in research and training but also in innovative clinical models.
- Grow journal readership, scholarship, and authorship as more academic psychologists would look to Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP) because they have more stake in it.
- Increase interdisciplinary collaboration for patient care within the integrated care movement.
- Facilitate opportunities for exploring models of integrated training.

At the Town Meeting at the AACAP Annual Meeting in October, some AACAP members expressed concerns about potential negative effects of extending membership to include psychologists. These fears included diluting the child and adolescent psychiatry perspective, losing our “home,” creating a slippery slope in which psychologist prescribing would be supported, or that other associate memberships would also be extended.

Although the idea of allowing psychologists to become members has been discussed from time to time, it is particularly relevant now with the increased focus on integrated care and the need for child and adolescent psychiatrists to have an impact beyond our small (by comparison to psychology and pediatrics) organization. Gregory K. Fritz, MD, AACAP President, created and charged a task force with exploring the issue, in part as one aspect of his presidential focus on integrated care.

Although we appreciate the “there goes the neighborhood” concerns of our colleagues who feel strongly that this is a poor idea, we feel it is inconceivable that non-voting, non-office holding psychologist members could “take over” or in any way steer the direction of the organization in ways that voting members and office holders did not want to be steered. In other words, AACAP will define and control the parameters of how the membership would look.

We not only have little to fear in terms of a takeover, we have little to fear that many of our colleagues would want to even join AACAP. In these days of dwindling resources and less opportunity to go to meetings and be a part of organizations, the desire of large numbers of psychologists to join us is probably not great. Our dues are relatively expensive, psychologists do not get continuing education credits to attend the meeting (and we doubt that the membership of psychologists would swell enough to support the staff that would be needed to change that), and only a few have networking interests with child and adolescent psychiatry. These colleagues would likely enrich some of our committees, however. Those of us who support this collaboration are all too aware of the fact that as child and adolescent psychiatrists, our voice is quite small. Their numbers are considerably greater than ours, and it is probably safe to say that their voice is louder in many arenas.

There are several ways we could see operationalizing a new membership category for psychologists. For instance, psychologists could be invited on a case-by-case basis to fulfill a component of journal function. Sponsorship for psychologists would still involve a need to apply formally and be sponsored by two child and adolescent psychiatrists. We could create exclusion criteria that would not allow admission to those whose values are not in line with AACAP’s or who otherwise are not a good fit. We can imagine many variations of this basic idea. A personal nomination with a suggested designated role may modestly increase interest and help us realize some of the advantages noted above.
A Case Against Creating a Membership Category for Psychologists

Debra E. Koss, MD, and Karen Pierce, MD

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 professionals needs of child and adolescent psychiatrists throughout their careers.

Children, adolescents, and families continue to encounter obstacles as they attempt to access care, and we as child and adolescent psychiatrists (CAPs), continue to come up against policies and regulations that interfere with our ability to practice medicine. Never has it been more important for AACAP to persevere in pursuit of our mission. To do so, AACAP must continue to serve as our professional home, organizing our membership and galvanizing our efforts to promote and advance psychiatric practice. Pursuing or creating a membership category for psychologists is not consistent with AACAP’s identified priorities, will deplete crucial resources necessary to achieve our goals, and will compromise advocacy strategies to protect scope of practice.

In 2011, Back to Project Future was established by AACAP Past-President Martin Drell, MD, to develop a consensus of priorities and action steps that would guide AACAP in the coming decade. With input from a diverse group of AACAP members, a shared vision and roadmap was developed, and ultimately, a set of goals and recommendations were approved by Council. During the implementation of Back to Project Future, a process was also established to review and update priorities on a biennial basis. The most recent set of priorities were approved by Council in October 2015. These priorities clearly focus on the needs of CAPs in the areas of Service/Clinical Practice, Training and Workforce, and Research. Initiatives developed from these priorities will serve to strengthen the depth and breadth of our expertise, advance our roles within psychiatric care teams, and expand advocacy efforts at the state and federal level.

To be effective in reaching our goals, AACAP needs to be intentional not only in the identification of priorities but also in the allocation of resources. We need to leverage our key resources including finances, the skill and dedication of AACAP staff, and the expertise and commitment of our members. All resources are finite. Therefore, developing a new membership category for psychologists will result in resources being redirected away from services and programs for CAPs. This is in direct opposition to the mission of our professional medical organization developed to meet the needs of CAPs throughout our careers.

Finally, healthcare continues to move in the direction of collaboration and integrated care. As CAPs, we routinely work with physician and non-physician mental health providers in support of children and youth. We know that the best interests of patients and populations are met when each member of the multidisciplinary team maintains competence in one’s own profession, appropriate to scope of practice. However, in 2016, psychologists continued their efforts to obtain broad prescribing privileges (RxP) and expand their scope of practice without sufficient education or training. Over half of all states have had some RxP legislation introduced. Last year, Iowa became the fourth state to pass a law allowing RxP, following NM (2002), LA (2004), and IL (2014). The American Psychological Association has endorsed RxP since 1993 and has provided state associations with model legislation.

The most recent version, approved in 2009, offers loosely defined parameters for didactic education consisting of “an appropriate number of didactic hours to ensure acquisition of necessary knowledge and skills” and “relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population.” In no way does this compare to the rigor of biomedical education and training that we receive as physicians. This raises serious concerns about children’s safety. As advocates for children and youth, we must continue to raise awareness about the distinctions between psychiatrists and psychologists. This includes our expertise as physicians to provide comprehensive medical evaluation and treatment planning as well as manage the complexities of prescribing psychotropic medication in children and youth. Inviting psychologists to become allied members of AACAP will serve to create further confusion among legislators and the public about the differences in our identity and roles. Additionally, it will compromise our ability to develop advocacy strategy and guarantee resources to protect our scope of practice.

To be responsive to the needs of our current members and serve the needs of children and youth with mental illnesses, AACAP must maintain a clear distinction between collaboration with psychologists and membership to our organization. Pursuing and/or creating a new membership category will redirect necessary resources away from our current priorities and risk threatening our scope of practice. As a professional medical organization, we have a responsibility to our members to provide life-long learning, advocacy, and leadership in health care innovation. Fulfilling our responsibility to our current members, we will fortify AACAP and unite CAPs. In turn, we as CAPs will serve as physician leaders working collaboratively with other physicians and non-physician mental health professionals on behalf of our patients. Collaboration will occur in service and clinical practice, training and workforce, and research, so that we may ultimately achieve our goal of promoting healthy development of children, youth, and families. ■
Child and Adolescent Psychiatrist Relationship With Psychologists – A Third Option

As part of an examination of our relationship with psychologists, AACAP is considering whether to expand our membership to include psychologists. In listening carefully to feedback given at the Town Meeting during the AACAP Annual Meeting in October 2016, as well as to perspectives from other members, it is apparent that many people are seeking alternatives to opening membership to psychologists. AACAP could focus on a “third option,” namely more effective collaboration with psychologists.

As we face our developing practice opportunities, in both traditional and innovative service delivery models, psychologists remain our valued interdisciplinary team members. As shown by an AACAP Assembly of Regional Organizations of Child and Adolescent Psychiatry (ROCAP) listerv this past summer, most participants collaborate in our daily work with psychologists, and most of us have developed collegial and mutually respectful relationships in optimizing care delivery. Many psychologists are already active in primary care offices and are involved in integrated care models, other sites of service delivery, and out into our networks of care.

Gregory K. Fritz, MD, President, AACAP, appointed me to the Task Force on Allied Membership for Psychologists (TFAM) as chair of the Assembly. To this task force, I have also brought my experience as a ROCAP delegate, an Advocacy Liaison, and as a member of AACAP Council, the Executive Committee, Healthcare Access and Economics Committee, Bylaws, as delegate to the Patient Centered Primary Care Collaborative (PCPCC), and, most importantly, as a practicing child and adolescent psychiatrist (CAP) in a variety of clinical settings. Each of these roles has influenced my thought process and search for productive and collaborative ways forward for the relationship between our specialties and our professional organizations. I want to thank Dr. Fritz for his leadership on integrated care and Tami D. Benton, MD, for her leadership of the Task Force for Allied Membership (TFAM).

Listening to Assembly delegates and serving as a panelist at the Town Meeting in October, I heard a resounding affirmation that we move forward with our collaboration with psychologists on integrated care. Dr. Susan McDaniel’s visit as president of the American Psychological Association (APA) and as an expert on integrated care, gives us further hope for the real deliverables for CAPs in this relationship.

I have further heard from members, including a wide representation at the Town Meeting – from private practitioners, from pediatricians who became child and adolescent psychiatrists, from those in teaching programs, from leadership, from Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), and from others— at least five ways that we could enhance and promote psychologists’ interest in and contributions to our organization, rather than a consideration for AACAP membership at this time:

1) Liaisons (at various levels of AACAP and APA).
2) Consideration of an alliance component within our organization, in which we have a body of CAP’s and psychologists collaborating on areas of mutual interest.
3) Useful projects and products supporting both of our fields and the contributors, such as joint practice parameters, policy statements, joint journal articles, etc.
4) Certificates of appreciation or acknowledgement from AACAP for special psychologist contributors to our organization.
5) Consideration to expand our JAACAP Editorial Board to include psychologists.

These considerations were also echoed and welcomed by some in leadership of the American Psychological Association, with whom I have an ongoing dialog.

Based on the feedback I noted, I recommend that AACAP add a “third option”—i.e. collaboration—to its consideration of our relationship with psychologists; I have listed several ideas above. Each member can send additional ideas to leadership, and I urge you to do so. Your suggestions will be considered as Council further deliberates on how best to enhance our relationship with psychologists—membership, traditional status, or a “third option” of wider collaboration.

We value your opinions as AACAP members and want to be sure to take into consideration your thoughts and feelings on the matter. Please send all feedback via email to communications@aacap.org. Your comments will be compiled and used in determining and defining the ongoing conversation. Also, if you have any questions, please contact the Communications Department directly via email at communications@aacap.org or by phone at 202.966.7300, ext. 119.

The deadline to submit feedback is May 5, 2017.
The Value of GAP: $V^{\text{GAP}} = \frac{Q}{C}$: The Secret of Multigenerational Professional Creativity

To my knowledge, the Group for the Advancement of Psychiatry (GAP) is the only organization of its kind in psychiatry, medicine, academics, business, or government in terms of its creativity, productivity, collegiality, and contributions to our field, our patients, medicine as a whole, and society. The value of GAP approximates infinity. How does an entity so inexpensive in monetary terms have so much value? Value is defined, at least in the healthcare world, as Quality divided by Cost ($V = \frac{Q}{C}$). Infinity could be realized either by the numerator ($Q = \infty$) or the denominator ($C = 0$). There is some cost to membership in GAP, so the value comes from GAP’s quality approaching infinity.

The factors contributing to the quality function include the structure of GAP, GAP members, and the origins and traditions of GAP. Without the structure put in place by the founders in 1946, GAP would by now have evolved like every other organization with noble beginnings, including those that continue to function well and provide a valuable service, but lose their creativity and the passion of the membership by becoming too large to function interpersonally, too bureaucratic to adapt to a constantly evolving mission, and too overly codified of which codification is often a good faith effort to preserve the original value of an organization. Codification eventually suffocates the human element. The human element being where the value of GAP is continuously recreated across generations, just as occurs every day in the natural world.

To my knowledge, we have never discussed this, but the present GAP membership of 222 Active and Life Members, and the current staff of 0.8 full-time employees, may be approaching the horizon of the ideal life-producing maximum that sustains the vitality of this organization. What is this wonderful structure that preserves the possibility of such vitality? It is the decentralized, bottom-up, committee-based foundation of GAP (Braffman 2006), in the context of the larger GAP organization whose purpose is to support the mission and efforts of each committee, while at the same time facilitating inter-group interaction and cooperation, and educational, collegial, and social interactions within the group as a whole. The tangible and intangible contributions of each committee tend to catalyze psychiatric, medical, and societal advancement through the creative processes of each committee outward to the larger world. Aside from maintaining this creative structure, GAP directly supports this vital process through a number of functions, such as the work of the Publications Committee, the Plenary Committee, the Ginsburg and Ittleson Fellowships, and liaison relationships with a number of interested psychiatric publications, as well as by interacting with the donor world, free of commercial erosions to the creative essence of GAP.

The founding members of GAP set the tone for the generations that followed. GAP is not an elite club, but there is a mutual selection process that results in a “think tank” friendly membership. The process is so intellectually stimulating and physically energizing that members rarely resign, but go out “with their boots on.” World War II had exposed how extensive the mental health problem was in the United States and how inadequate were the services available. An unexpectedly high percentage of draft rejections for psychiatric reasons, huge numbers of wartime psychiatric casualties, deteriorating public mental hospitals, and an almost total absence of community services caught the attention of psychiatrists, especially those who had served in the military, as well as the general public (Deutsch 1959).

GAP was born on May 27, 1946, in Chicago, out of a post-war social reform movement for the mentally ill. Some of the initial leaders are still relatively well known today, including William Menninger, Karl Menninger, Henry Brosin, Roy Grinker, and O. Spurgeon English (English 1946). I had the good fortune of meeting Spurgeon English at his Philadelphia home in the 1980s where he was still seeing patients at the age of 85; and more importantly, still intellectually alive— the epitome of a GAP member! Membership in GAP is not a stepping-stone to National Institutes of Health grants, academic advancement, chairmanships, or large book contracts. I often joke that the idea of a “psychiatric think tank” is an oxymoron. Part of my point is actually that the process is more fundamental than evoked by the standard think tank. A fellow AACAP Research Committee member coined the idea that the creative process of GAP is

“To my knowledge, the Group for the Advancement of Psychiatry (GAP) is the only organization of its kind in psychiatry, medicine, academics, business, or government in terms of its creativity, productivity, collegiality, and contributions to our field, our patients, medicine as a whole, and society. The value of GAP approximates infinity. How does an entity so inexpensive in monetary terms have so much value? Value is defined, at least in the healthcare world, as Quality divided by Cost ($V = \frac{Q}{C}$).”
“conversational thought,” which distinguishes what GAP facilitates from the vision of experts writing position papers in the solitude of their private offices.

The ongoing multigenerational creativity of GAP results in what we commonly refer to as “GAP products,” publications reviewed, edited, and approved by the GAP Publications Committee, which appear in a wide range of media, including media available to the general public, thus continuing the tradition of informing and influencing at a societal level. There are also intangible GAP products, outcomes of GAP participation that we observe but cannot measure, i.e., better patient care, teaching, supervision, leadership, and the publication of non-GAP articles, all catalyzed and influenced by the GAP version of a think tank. The GAP version of a think tank is more in line with what former Ittleson Fellow, Walter J. Freeman, M.D., one of the leading neuroscientists of the 1980s, 1990s, and 2000s, once wrote (Freeman 1995): “The most important function of brains . . . is to interact with each other to form families and societies.” GAP is a society of brains interacting for the benefit of our patients, our field, and society as a whole. The Value (V) of GAP approaches infinity because the Quality (Q) of GAP does.

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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.
We once again thank Fred Seligman, MD, for being AACAP’s official photographer! Fred’s efforts are not only beautifully detailed, but they successfully capture the true essence and wonderful spirit of AACAP!
63rd Annual Meeting Recap
63RD ANNUAL MEETING RECAP
63rd Annual Meeting Recap
63rd Annual Meeting Recap

[Images of people posing at a conference event, including stakeholders and attendees. The photos show various groups and individuals, highlighting the social aspect of the annual meeting.]

[Images of a musical performance, emphasizing the entertainment aspect of the conference.]

[Images of the venue and decor, giving a glimpse into the setting of the annual meeting.]
63rd Annual Meeting Recap
Missed AACAP’s 63rd Annual Meeting? Interested in Educational Resources?

We have several ways that you can reap the benefits of AACAP’s valuable educational content, including:

- Session recordings
- Institute notebooks
- Speaker handouts from AACAP’s 63rd Annual Meeting
- Lifelong Learning Modules with self-assessment and CME credits

Exciting features!

- Session recordings from the 2016 Annual Meeting include PowerPoint Slides
- All Annual Meeting Institutes are bundled for a new low price!

Topics include:

~ advanced psychopharmacology ~ autism ~ eating disorders ~ assessment and tools for child and adolescent psychiatrists ~ and much more!

NEW THIS YEAR – Access two session recordings for free from the Psychopharmacology Institutes featuring Boris Birmaher, MD, and his presentation “Depression in Children and Adolescence” and Timothy E. Wilens, MD, and his presentation “ADHD: Focus on Pharmacotherapy.”

Access these and other session recordings by visiting http://aacap.sclivelearningcenter.com.

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To access speaker handouts from the Annual Meeting:
Log in to www.aacap.org, and then go to the 63rd Annual Meeting homepage at www.aacap.org/AnnualMeeting/2016 and click on the link for the Annual Meeting Itinerary Builder.

**Clinical Perspectives: Treating Sleep Problems in Children and Adolescents**

I am consistently surprised by the number of children and adolescents clutching Starbucks cups! Perhaps it is no coincidence that clinicians’ interest in pediatric sleep disorders has grown, demonstrated by attendance at AACAP’s 2016 Clinical Perspective “Bath, Bed, and Beyond: Treating Sleep Problems in Children and Adolescents,” chaired by Anna Ivanenko, MD, PhD, and Jess Shatkin, MD, MPH. Presentations focused on assessment and management of sleep disorders. Sip your coffee as we review.

The first step is recognition. Presenters emphasized taking detailed sleep histories. Judith Owens, MD, MPH’s mnemonic “BEARS” helps: B-bedtime issues; E-excessive daytime sleepiness; A-awakenings/abnormal behavior; R-regularity/duration of sleep; S-snoring. Practitioners who use the BEARS mnemonic identify twice as many sleep problems among their patients. The sleep history should further clarify the sleep schedule, including bedtime, wake time, awakenings, naps, and variability in schedule. Bedtime routine, screen use, and environment (room, co-sleeping) should be assessed. Snoring, gasping for air, abnormal movements/behaviors, sleep paralysis, enuresis, daytime sleepiness, and medical and psychiatric disorders are other important factors.

Argelinda Baroni, MD, introduced parasomnias in “Half Asleep: An Overview of Sleep Terrors and Sleepwalking.” Parasomnias are episodic behaviors or experiences during sleep, and are classified into disorders of arousal (DOA, from non-REM sleep), parasomnias associated with REM sleep, and other parasomnias. DOA from non-REM sleep are common in children, and include confusional arousals, sleepwalking, sleep terrors, and sleep-related eating disorder. These occur during slow-wave sleep (SWS), generally in the first third of the night. Episodes have variable frequency and present with confusion or disorientation and limited recall. Attempts to wake the child often result in increased agitation. DOA and nocturnal seizures share some clinical manifestations, so it is important to consider seizures in the differential.

Sleep terrors occur in 1-6% of children, with predominance in younger years and resolution typically by adolescence. Seventeen percent of youth have regular sleepwalking episodes. Genetic predisposition, medications, and disorders with sleep disruption (SD) predispose to DOA; history helps target comorbidities and environmental factors that perpetuate DOA. Clinicians should assess for dangerous behaviors and establish safety; this may include securing doors and windows, locking away medications and firearms, and managing sleepovers. Suspension of neurological or sleep disorders, frequent episodes, or dangerous behaviors may require referral for a full sleep study, including polysomnogram. Further treatment includes educating parents to direct children back to bed, teaching sleep hygiene, and scheduling awakenings. Low dose benzodiazepines may be indicated for severe episodes; tricyclic antidepressants (TCAs) may be tried if benzodiazepines are ineffective.

Reut Gruber, PhD, then explained the impact of impaired sleep in “Sleep and Emotional Regulation in Children and Adolescents.” Up to 95% of youth with internalizing disorders also experience sleep disruption (SD). In addition, SD contributes to further depression and anxiety, increases irritability and negative thinking found in depression, and intensifies cognitive distortions associated with anxiety. SD is thought to impair the prefrontal cortical/amygdala connectivity, thereby limiting individuals’ ability to inhibit negative thoughts and contributing to depression and anxiety. Cortisol dysregulation and altered stress response also have been shown to be related to sleep disruption.

Links between insomnia and anxiety/depression are significant because insomnia exacerbates internalizing conditions, reduces treatment effectiveness, and increases relapse risk. Understanding SD allows incorporation of insomnia-focused treatments. Cognitive behavioral therapy for insomnia (CBT-I) shortens sleep latency and improves sleep efficiency. CBT-I includes sleep education, sleep hygiene, stimulus control, sleep restriction, and therapy surrounding sleep thoughts and beliefs (i.e., “Sleeping poorly once ruins my sleep all week”).

Next, Dr. Ivanenko discussed the overlap of SD and attention-deficit/hyperactivity disorder (ADHD) in “Insomnia and ADHD: Rational Approach to Treatment.” Sleep, arousal and attention systems share neurotransmitters and anatomical sites in the brain. Dysfunction in these areas leads to impaired affect regulation, learning, memory, and processing, contributing to behavioral and school problems, which ultimately disrupt family functioning. Over half of children with ADHD have SD, including night awakenings, sleep-disordered breathing, restless sleep, excessive sleepiness, and difficulty falling asleep. Clinicians can use parent interviews, standardized rating scales, or sleep diaries to gather more information. While polysomnograms reveal that children with ADHD have increased stage I (or light stage) sleep, and actigraphy suggests increased nocturnal awakenings and variability of sleep-onset time and sleep duration, meta-analyses show few differences in objective sleep measures. Children with ADHD may have poorer sleep hygiene, altered sleep drive, sleep phase delay, and impaired wakefulness due to arousal dysfunction or increased daytime sleepiness.

Management of insomnia with ADHD includes promoting sleep hygiene,
behavioral interventions, and, lastly, incorporating medication. Insomnia with stimulants is dose-dependent, and non-stimulants may also cause insomnia. Prescribing the lowest possible stimulant dose, changing formulation/class of stimulants, or using non-stimulants, melatonin, or alpha agonists are pharmacologic options. Defining expectations and combining behavioral plans is essential. Behavioral techniques include adjusting bedtime, establishing age-appropriate bedtime and routines, setting firm rules, and eliminating arousing activities.

Delayed sleep phase disorder, which is relatively common among adolescents with ADHD, is persistent delayed sleep onset/wake times, resulting in insomnia causing functional impairment, social difficulties, and depression. Treatments include education, medication adjustments, light therapy, and melatonin.

Youth with ADHD and restless legs syndrome (RLS) present with tickling, squeezing, or aching legs. Sleep is restless, and affected individuals may experience increased daytime sleepiness, behavioral problems, and ADHD symptoms. Forty-four percent of children with ADHD have RLS symptoms, which may be due to an overlap in symptoms, shared neurobiological mechanisms, iron deficiency, and/or dopamine dysfunction. Treatment of RLS typically involves iron supplementation and avoiding exacerbating factors.

Finally, Dr. Owens discussed excessive daytime sleepiness (EDS) in “The Sleepy Teen: Evaluation and Management.” EDS is the inability to stay awake and alert during the day, resulting in periods of irrepressible need for sleep or lapses into drowsiness or sleep. In Type 1 Narcolepsy (cataplexy), children have sudden, transient loss of muscle tone, often triggered by strong emotions. Additional symptoms include sleep paralysis and hypnagogic and/or hypnagogic hallucinations. Other hypersomnias include idiopathic hypersomnia and, rarely, Klein Levin syndrome.

Narcolepsy confers greater risk for attention and cognitive dysfunction, creating educational struggles; youth show poorer social and emotional functioning and are at increased risk for physical comorbidities. Children with EDS require an adequate sleep and neurological work-up, which might include polysomnography, multiple sleep latency test, neuroimaging, and HLA-genotyping.

Pharmacologic management for narcolepsy is first-line and includes psychostimulants, modafinil, and armodafnil. Selective serotonin reuptake inhibitors may improve cataplexy by suppressing rapid eye movement (REM) sleep and increasing slow-wave sleep (SWS). MAOIs and SNRIs have limited data supporting their use. TCAs suppress REM and SWS and increase REM latency; however, withdrawal nightmares, parasomnias, and side effects make these less appealing. Sodium oxybate is the only medication approved for Type I narcolepsy in adults. Downsides include danger in overdose, cost, and difficult dosing regimens. Behaviorally, napping, sleep hygiene, nutrition, exercise, caffeine, systematic desensitization, imagery rehearsal therapy, yoga, mindfulness, psychotherapy, and support groups may improve outcomes. CBT for narcolepsy involves psychoeducation and behavioral interventions to improve medication adherence, nocturnal sleep and daytime alertness.

In conclusion, pediatric sleep disorders are highly prevalent. The Clinical Perspectives emphasized the importance of detailed assessment to guide behavioral and pharmacological treatment of sleepy youth in our practices.

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Sexting, Revenge Pornography, and Digital Dating Abuse: New Research on Adolescent Digital Behaviors

Emerging research is examining sexualized digital behaviors and digital forms of dating abuse among adolescents. Digital technology and social media are primary methods of communication between youth of all social classes. Digital communications are largely used for positive interactions but are also a vehicle for harassment and threat. Digital communications that are part of troubled romantic and sexual relationships can be fatal: Jessica Logan and Amanda Todd were both young girls who tragically committed suicide after their nude photos were widely circulated. Similar problems include using relentless social pressure, empty promises, coercion, or bullying to obtain nude photos; releasing nude photos following the end of a relationship (“revenge porn”); debasing and humiliating peers for real or imagined sexual activity (“slut shaming”); and using objectionable misogynistic language in digital environments. This symposium presented and reviewed several current studies on these topics and others related to digital dating behaviors.

Elizabeth Englander, PhD, from the Massachusetts Aggression Reduction Center at Bridgewater State University in Massachusetts, presented on sexting (defined as sending a nude image of oneself to a peer). Although sexting is often viewed as rare and inevitably linked to psychopathology, recent research suggests otherwise. The proportion of youth who report having sexted has increased each year over the past four years, while some harmful outcomes (such as being bullied or harassed following sexting) have remained stably infrequent. Several studies have found that a substantial minority of youth sext, and that many sexters show no indications of psychological distress. Still, a high-risk subsample (22%) may sext for psychologically unsound reasons. These high-risk sexters are more likely to be sexting under pressure, sexting to a partner outside of a stable relationship, and sending a picture to multiple recipients. Unauthorized sharing and “Revenge Porn” were significantly more frequent in poor-outcome sexters. Finally, youth who reported “pre-violence” risk factors (such as an excessively controlling partner) were significantly more likely to report negative outcomes after sexting.

Next, Joris Van Ouytsel, MSc, a doctoral student at the University of Antwerp, spoke about cyber dating abuse. He described several studies examining psychological and emotional forms of dating abuse that occur through digital technology, more specifically digital controlling behaviors, including the abuse of passwords and pin codes, and using technology to control or track the whereabouts of a partner. Van Ouytsel noted that jealousy often seemed to be the genesis of these activities and that intervention programs might focus on techniques to reduce jealousy. Digital dating abuse was associated with other high-risk behaviors, most notably alcohol abuse, the number of sexual partners, and unsafe sex practices. As with many other high-risk behaviors, perceived social norms were the most important predictors of digital dating abuse. Such abuse was also influenced by parental relationships and gender stereotypes. All of these findings strongly suggest the potential efficacy of education and awareness as a key mechanism for reducing digital dating abuse.

Christopher Houck, PhD, next presented his research, conducted with Sarah Johnson, MA, examining controlling digital behaviors in early adolescents with mental health symptoms. He began by reviewing research that has established the ubiquitous nature of technology use by teenagers today. Teens use technology extensively in their dating relationships, both to communicate with their partners and to satisfy contemporary expectations about frequent communication between partners. Houck referred to what others have called the “electronic leash.” He pointed out that such communications sometimes go awry, resulting in verbal, emotional, physical, and sexual abuse between partners. This can include put-downs, controlling behaviors, assault, and coerced sex. As a result, the victim may experience problems such as substance abuse, aggression, isolation, anxiety, depression, and even suicidal ideation. Dr. Houck pointed out that digital abuse or controlling behaviors by a partner are reported by 20% to 30% of youth. One quarter of teens in a relationship reported cyber dating abuse in one study, and 10% reported reciprocal digital abuse. Another study found that 41% of teens experienced digital dating abuse from their dating partners, the most common forms being a partner who seeks passwords or access to “check up on” social media activities. Digital abuse and traditional dating abuse were significantly related in this study, and Dr. Houck emphasized the need for practitioners to assess for both types of behaviors in their young patients.

Sexting and digital dating abuse were studied together by Jeff R. Temple, PhD, who reported on his research with Hye Jeong Choi, PhD. Dr. Temple found that, among both male and female subjects, 28% reported having sexted while 68% of females and 42% of males were asked for a nude or sexual photo. Overall, females were more disturbed by these requests. In this prospective longitudinal study, Dr. Temple found that subjects reported decreasing likelihoods of being asked to sext as they aged, but increasing likelihoods of sending and receiving sexts. He pointed out that sexting “matters,” not least because it is associated with physical sexual activity, a behavior that is firmly within the domain of public health. Sexting was also associated with cyber dating abuse, but only for male subjects. Dr. Temple’s study is one of...
the few that examines sexting longitudinally, and the one clear finding was that subjects were more likely to sext as they aged, especially females. He termed this the “Break the Seal” phenomenon – once a young person has sexted, he or she is more likely to continue the behavior.

Finally, Christie Rizzo, PhD, reported on her research examining dating violence and digital abuse among high-risk adolescent girls, conducted with Meredith Joppa, PhD. Dr. Rizzo framed digital dating abuse as a public health problem, noting that traditional dating violence is widely recognized as a public health threat. She found that traditional and cyber dating abuse were related. Females were at particularly high risk although the research is nascent and more studies are needed. Depression was strongly related to dating violence, especially in adolescent females, and the links are bi-directional. Time spent on social media sites was positively correlated with depressive symptoms, but research has not yet clarified a relationship between digital abuse and depression. Emotional regulation was examined in this study as a possible risk factor for dating violence. Emotional regulation was not associated with either type of abuse (digital or in person). The relationship between emotion regulation problems and dating violence was mediated by interpersonal hostility, suggesting that such problems could be a consequence of witnessing or experiencing violence while young. In Dr. Rizzo’s research, victimization and perpetration were highly correlated and often co-occurred. Dating violence and digital abuse predicated each other at different stages of the longitudinal study.

Although the panel’s research varied in methodology and design, the findings were remarkably consistent. Each study found that digital expressions of relationship dynamics, such as high-risk sexting or digital dating abuse, were significantly related to traditional types of dating violence and high-risk behaviors and thus should be studied more extensively as indicators of risk and possibly mental health suffering. Digital behaviors were not separate, distinct, or unrelated to other measures of problem behaviors and emotions. Practitioners were urged to consider how to assess for and treat these problems; they should not be ignored as irrelevant or unimportant by public health, research, or clinical communities.

Elizabeth K. Englander is a professor of Psychology and the founder and director of the Massachusetts Aggression Reduction Center at Bridgewater State University, which delivers programs, resources, and research for the state of Massachusetts and nationwide. She is a nationally recognized researcher and expert in the area of bullying and cyberbullying, childhood causes of aggression and abuse, and children’s use of technology. She may be reached at ekenglander@gmail.com.

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

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

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

Alvin Rosenfeld, MD
Photo Editor, AACAP News
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Community Crisis and Community Resilience: The Children of Flint, Michigan

Water-based lead exposure, adverse childhood events (ACEs), and other sources of trauma can occur in any community. Understanding the water crisis and related response in Flint, Michigan, along with the neurocognitive impact of low-level lead exposure in childhood and the impact and treatment of trauma exposure, empowers practitioners to promote child health and wellness through enhancing individual knowledge and skills, building partnerships, and collaborating across community sectors.

Flint residents were exposed to lead in their water supply through a series of preventable human errors. Toxic levels of lead were identified in the water by researchers from Virginia Tech. Local investigators then demonstrated that increased water lead levels were associated with increased blood lead levels in children. The exposure to lead increased the overall proportion of children in Flint with elevated blood lead levels and also increased the disparities between neighborhoods. Given this information, officials switched Flint back to a safer water supply. However, the pipes were already damaged. When the water in Flint will again be safe for consumption is unclear.

Lead is a potent neurotoxin with lifelong impacts; there is no safe level of lead in the body. Therefore, the best protection of children from lead is primary prevention. Unfortunately, exposure to lead is most likely to occur in communities that face poverty and poor infrastructure, impacting the most vulnerable populations and widening pre-existing disparities. While there are many limitations to the current body of evidence around lead’s impact on neurodevelopment and neuropsychological function, it is possible to draw several conclusions. Low-level lead exposure (<10μg/dL) is associated with a decrease in IQ; an increase in blood lead level from 1 to 4μg/dL drops mean IQ 3.7 points. This small shift for an individual can have large population level effects; as the mean IQ of the population shifts lower, there are more individuals who will require educational intervention and fewer ‘high achievers.’ Low-level lead exposure is also associated with poorer executive function and more hyperactive and impulsive behaviors.

Importantly, low-level lead exposure does not occur in isolation. Many children exposed to lead are also exposed to significant adverse childhood experiences (ACEs) and other forms of trauma, which should be considered when designing and implementing lead-exposure interventions. Trauma and toxic stress can have a significant impact across multiple domains of development, including physical, cognitive, emotional, and social development, and can fundamentally alter a child’s life trajectory. Trauma-focused psychotherapies, including Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and Child Parent Psychotherapy (CPP), should be considered first-line treatments for children and adolescents with symptoms of posttraumatic stress disorder. TF-CBT is conjoint child and parent psychotherapy for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic events. In TF-CBT, children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related to traumatic life events; and enhance safety, growth, parenting skills, and family communication. CPP has been shown to significantly improve children’s trauma-related symptoms and overall behavioral problems and is evidence-based for young children and their caregivers. For children with concomitant lead and trauma exposure, parallel referrals to connect with resource needs, diagnostic clarification, and trauma-informed services are likely to have synergistic positive effects.

One potential referral model is the Michigan Child Collaborative Care (MC3) Program. In the state of Michigan, MC3 provides psychiatry support to primary care providers who are managing patients with mild-to-moderate behavioral health problems. Behavioral consultants are located within the primary care practice and help to connect families with appropriate resources, skills, and treatments, including trauma-informed care. Psychiatrists are available through educational phone consultations to offer guidance on diagnoses, medications, and psychotherapy interventions so that primary care providers can better manage patients in their practices. Psychiatrists can also provide video telepsychiatry evaluation of patients and families. Since its launch in Michigan in May 2012, the group has enrolled 1,142 primary care providers and completed phone consultation on 92 children ages 0-5.

Children who suffer from trauma and abuse are at risk for significant morbidity.
The MC3 psychiatric consultants provide education and support to primary care providers who are treating children with trauma histories, including consistent education about the effects of trauma and the misdiagnosis of trauma, as well as the importance of appropriate pharmacological treatment and engaging in trauma informed care when necessary. MC3 began enrolling primary care providers within the Flint community in spring 2016 and is an important piece of Flint’s ongoing efforts to buffer the impact of lead exposure.

In responding to the water crisis, the first step was to address the water and to ensure the availability of safe water for consumption. This is an ongoing effort. Pipe replacement began in September 2016. In the interim, efforts toward secondary prevention ensued. In the case of lead exposure, interventions that buffer impact and build resilience are the same interventions used for other ACEs and health promotion, but in Flint they are now newly recognized and prioritized. The interventions focus on promoting healthy nutrition, connecting children with early childhood education, supporting primary caregivers, and strengthening the medical home. Across Flint, individuals and organizations are partnering to reduce duplication, maximize resources, and innovate.

Organizational leaders include Genesee Health System Community Mental Health, Hurley Children’s Hospital and Clinic, and the Pediatric Public Health Initiative, among many others. Flint has a lot of work ahead, and there are Flints everywhere. Those working for child health and wellness in Flint hope to shine a light on other forgotten places surrounded by disparities and ACEs. In five, 10, and 20 years, thinking about Flint may recall thoughts of contaminated water supplies, but also to the children of Flint, the fighting spirit of the community, and how hope, resilience, and optimism resulted in defying the odds and creating a model response for the nation.

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Clinical Perspectives: “Is the Next School Shooter Sitting Before Me?” Critical Issues in School Threat Assessment

Deborah Weisbrot, MD, chaired this Clinical Perspectives, which reviewed essential aspects of threat assessment in youth, highlighted the complexities and challenges of these evaluations, and addressed the controversy as to whether there is a heightened risk of serious threat behaviors in individuals with autism. An additional focus was on the media’s potential role in creating blueprints for school shootings and how the clinician should examine the intensity of a student’s interest in the lives and methods of prior mass shooters.

Dr. Weisbrot presented an overview of threat assessment in children and adolescents, including estimating severity, degree, and type of threat. Although extremely rare, school shootings are an intense focus of public concern. After Columbine, schools instituted zero tolerance policies, which led to the rapid removal from school of any student who made a threat, rather than addressing bullying and violence. Dr. Weisbrot highlighted how this policy has not been helpful in addressing school threats. She also examined the common myth that school shooters are loners and bullying victims. In fact, experts in this field indicate that there is no uniform profile of the school shooter. One common feature among shooters was the tendency to reveal their plans before the shooting occurred through direct threats or indirectly, e.g., in drawings, diaries, or school essays. “Leakage” is the term used for the ways in which an individual intentionally or unintentionally reveals vital clues to feelings, thoughts, fantasies, attitudes, or intentions before a violent act.

Prevention depends on the ability to identify high-risk youth. Unfortunately, there is no magic checklist, application, or computer program that can definitively predict which student is likely to carry out a threat. There is no substitute for the child and adolescent psychiatrist’s thorough evaluation to gauge the severity and intensity of the threat. Effective threat assessment requires an integrated systems approach, collection of facts, as well as the understanding of the process of thinking and behavior for targeted violence. A model was presented in which targeted violence in school was viewed as the final act on a pathway to violence. Different types and degrees of internal psychological, situational, and interpersonal processes are involved along this pathway. Each stage has its own pattern of warning behaviors and is accompanied by a crisis in the student’s life.

Threat assessment plays a central role in the prevention of targeted violence in school. Dr. Weisbrot presented data showing that typically there is at least one person with pre-offense knowledge who often expresses concern (albeit insufficiently) pre-incident. There is no question that availability of firearms raises the level of risk for an act of violence. Timely recognition can lead to early prevention. School threat assessment teams are also essential to investigate any threat that occurs; these should be implemented in every school. Threat assessment does not end after a psychiatric evaluation that permits the student to return to school. The student needs to be followed throughout his educational career.

John N. Constantino, MD, presented on the co-occurrence and interaction between autistic traits and aggression. Individuals with autism spectrum disorders (ASD) are, in fact, no more violent than those without ASD. However, among those with autism with more aggressive tendencies, their comorbid psychopathology, deficits in social interaction, and emotional regulation problems are possible factors that potentially underlie violent behaviors. The presence of callous-unemotional traits in individuals with ASD may reflect a “double hit” of impaired empathic response to distress cues. Clinicians evaluating students with ASD who have made a threat need to assess the role played by cognitive rigidity, as well as the impact of severe bullying and teasing, which is often experienced by these children. Dr. Constantino emphasized that the behaviors of Adam Lanza (the perpetrator of the Sandy Hook shootings) were not at all typical of those with ASD. Media reports have unfortunately exaggerated community perceptions about violence proneness of youth with ASD. It is crucial for clinicians to advocate for the ASD population and fight against further stigmatization.

Aradhana “Bela” Sood, MD, provided a psychological autopsy of Seung Hui Cho, the perpetrator of the Virginia Tech massacre. She reviewed systemic gaps at the college level and in the state public mental health system that led to missed opportunities for preventing the tragedy. To avoid such gaps, it is important to have critical knowledge about exceptions in laws (HIPPA/FERPA) in order to
Dr. Sood emphasized the need to have a culture of community on campus and to break down silos within the university system in order to improve transparency and communication. To avoid future tragedies, varying levels of prevention are needed, including: primary prevention in which the student body and faculty are educated about mental health; secondary prevention in which all students receive a basic mental health screening; and tertiary prevention in which students who need help, receive it right away.

The impact of media coverage on school rampage shootings was presented by Dr. Weisbrot. Reports showed significantly elevated threat levels in the immediate days and months after high-profile school shootings. The majority of school rampage shooters have idolized a shooter who has gone before, with explicit reference to the Columbine shooters. Cyberspace provides an ideal medium for potential school shooters to interact with anonymous supporters of violence. Widely available information on prior shootings can provide a blueprint, allowing potential perpetrators to have access to details, preparation, and instructions for carrying out a shooting. It is crucial to explore a student’s intense interest in violent fantasies or preoccupation with violently themed media.

The session’s discussant, Gabrielle A. Carlson, MD, assimilated the themes and concerns from all speakers by presenting the case of an adolescent who had made an explicit, high-level threat. Dr. Carlson emphasized the need for a thorough evaluation to recognize the unique mixture of developmental histories, difficulties in coping, psychological vulnerabilities, and perpetrators’ beliefs. In order to assess threat credibility, one needs to obtain threat details, prior behavior reports, and psychiatric and previous educational evaluations. In some cases, a therapeutic day treatment program or hospitalization should be strongly considered. A lively discussion among faculty and audience ensued. By the conclusion of these presentations, it was clear that the topics covered in this Clinical Perspectives session on threat assessment were of critical concern to all child and adolescent psychiatrists.

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Research Institute: Epigenetics in Child and Adolescent Psychiatry

The Research Institute, chaired by Jean A. Frazier, MD, (University of Massachusetts Medical School) and Jeremy M. Veenstra-VanderWeele, MD, (Columbia University) focused on epigenetics in child and adolescent psychiatry. Epigenetics refers to modifications to DNA that affect gene expression and function, including DNA methylation and histone modification.

Stacy S. Drury, MD, PhD, (Tulane University) focused on the role of telomeres, regions of repetitive nucleotide sequences at the end of each chromosome providing protection from deterioration or damage. A key process of aging is the gradual shortening of telomeres in response to stresses in the environment. Dr. Drury presented data on the impact of early life stress on telomeres and how this may be implicated in the well-documented poor health outcomes of adverse childhood events. A hallmark study was the Bucharest Early Intervention Project, in which children abandoned at or around the time of birth were randomized to high-quality foster care or to remain in institutional care. The percentage of time in institutional care was a predictor of accelerated decline of telomere length, and those with “poor” health at age 12 years also had significantly shorter telomeres than those with “good” or “excellent” health. Likewise, in the pioneering New Orleans Stress Physiology and Children Study, telomere length was associated with cumulative family violence and disruption in children aged 5-15 years. There were interesting race and gender effects in that black females had significantly longer telomeres at birth, and this increased length predicted a faster decline in length, intensifying the “aging” effect of the environment. The ongoing Infant Development Study examines the impact of prenatal stress on infant biology and physiology. Early data suggests that accelerated aging and shorter telomere length prenatally may explain the higher rates of preterm delivery and low birth weight in black populations in the study. The presentation highlighted multiple lines of evidence that telomeres may mark cumulative exposure to adverse childhood events, provide insight into how these events impact long-term health, and ultimately may provide an indicator of treatment efficacy for interventions aimed at ameliorating these effects.

Frances A. Champagne, PhD, (Columbia University) continued the discussion of early life experiences and how epigenetics mediates the effects of maternal experiences occurring pre-conceptually, prenatally, and postpartum on offspring development. She presented evidence from a rat model in which chronic variable stress during pregnancy altered expression in the rat placenta of multiple stress-related genes by epigenetic DNA methylation. The epigenetic effect was a mediator for the effects of environmental exposure on rat neurodevelopmental outcomes. She linked this finding with clinical data on effects on child development of prenatal exposure to bisphenol-A by demonstrating that in a rat model bisphenols induce tissue-specific epigenetically-mediated changes in gene expression, which lead to neurodevelopmental, metabolic, and immune changes. She concluded by presenting fascinating evidence of an “epigenetic interplay” between paternal and maternal experiences that have complex effects on neurobehavioral outcomes as well as hypothalamic gene expression.

Catherine Monk, PhD, (Columbia University) continued the theme of using epigenetics to understand how distress during pregnancy impacts fetal behavioral outcomes. Her work is based on the hypothesis that in-utero exposures change physiology and metabolism in ways that affect long-term outcomes. Dr. Monk described methods to directly examine the fetus by monitoring fetal heart rate and fetal heart rate reactivity in response to in-utero exposures. Third trimester fetal heart rate reactivity differs by the mother’s trait anxiety levels and psychiatric status – mothers with comorbid anxiety and/or depression have fetuses that exhibit greater heart rate reactivity in response to maternal stress. Functional MRI data suggest that prenatal maternal depression alters the connectivity between amygdala and prefrontal cortex in six-month old infants in ways that are more reminiscent of adult connectivity. Thus, the fetus responds to maternal prenatal distress with accelerated maturation leading to early heightened awareness, reactivity, and vigilance. Finally, Dr. Monk tied in her findings with the epigenetic studies presented by Dr. Champagne, presenting evidence that epigenetic regulation of placenta glucocorticoid-related genes affects the hypothalamic-pituitary-adrenal axis during pregnancy, mediating the effects on third trimester fetal behavior and potentially neurodevelopmental outcomes.

Schahram Akbarian, MD, (Icahn School of Medicine at Mt. Sinai) presented a lifespan perspective of how risk factors present in early childhood are associated with lasting epigenetic dysregulation and cognitive alterations, drawing on the postmortem brain research literature. Many genes involved in monogenic neurodevelopmental disorders code for proteins involved in regulation of chromatin remodeling through epigenetic modifications. Many of these genes are also related to cognitive deficits and neurobehavioral changes in rodent models. Evidence from human and rodent studies shows that early childhood malnutrition can lead to significant changes in the epigenome in adults that may mediate the intergenerational transmission of psychiatric risk after exposure to early childhood adversity.
Amir Levine, MD, (Columbia University) presented his intriguing research into the role of epigenetics in the effect of nicotine exposure on subsequent response to cocaine exposure. In epidemiologic studies, 90% of cocaine users smoked cigarettes prior to cocaine use, and onset of cocaine use after smoking doubles the risk of cocaine dependence. In rodent models, regular nicotine use for seven days dramatically enhances the neurobehavioral and electrophysiologic effects of subsequent cocaine use, enhancing the long-term potentiation (disinhibition) induced by cocaine in the nucleus accumbens. Cocaine exposure leads to epigenetic modification by histone acetylation of the promoter region for the FosB gene, leading to increased FosB expression, which is correlated with addictive potential of cocaine. Nicotine pretreatment enhances this effect, and pretreatment with a histone deacetylase (HDAC) inhibitor mimics the effects of nicotine. Inhibiting histone acetylation or activating HDAC prevented the long-term potentiation and FosB enhancement induced by cocaine exposure. In addition to providing a mechanistic explanation for the “gateway” effect of nicotine on later cocaine use, Dr. Levine’s studies raise the question of the possible use of HDAC activators or histone acetyltransferase inhibitors in preventing or reversing addiction-related behaviors.

Finally, Jay A. Gingrich, MD, PhD, (Columbia University) presented evidence that age-related DNA methylation changes in sperm may explain the epidemiologic association of advanced paternal age with increases in single gene mutations, increases in incidence of sporadic autism, and increased risk for multiple psychiatric disorders. Advanced age in mice is related to decreased sperm DNA methylation in several areas of the genome adjacent to CpG islands involved in controlling transcriptional activity of genes. Offspring of mice with advanced paternal age have an attenuated decreased DNA methylation in the same genome locations as found in the father’s sperm, indicating some heritability of this epigenetic modification. These DNA methylation changes have also been identified in sperm of human males of advanced age, and 16 affected genes have been identified that are known neurodevelopmental factors related to increased risk of autism and schizophrenia.

Overall, this Institute provided a comprehensive overview of multiple areas in child and adolescent psychiatry where epigenetic changes are related to important clinical findings, turning the nature versus nurture argument on its head by describing how “nurture” can drive changes in “nature.” The research challenges for future work include the use of epigenetics in early identification of those at risk for development of psychiatric disorders, as well as the development of clinical interventions that may prevent or reverse the epigenetic changes at the heart of these intriguing clinical findings.

Dr. Cochran is assistant professor of Psychiatry and Pediatrics at University of Massachusetts Medical School and assistant medical director of the UMASS Center for Autism and Neurodevelopmental Disorders (CANDO). He can be reached at david.cochran@umassmemorial.org.
Simon Wile Symposium: Screening, Adhering, and Dying: A Collaboration with Subspecialty Pediatrics

Dr. Sulik, after graciously accepting his award, began his presentation: “Transforming Health and Wellness Through Dynamically Integrated Health Care: A Big Solution to Health Care’s Big Problems,” with a thought-provoking example from the food service industry. Caribou Coffee and Bruegger’s Bagels, individually each offered an excellent product, but only half of a perfect breakfast; leading consumers to frequent each store separately to meet their needs. When the two companies integrated into one shared location, they were able to seamlessly deliver better service.

Dr. Sulik segued with the metaphor: “if primary care is the food, psychiatry is the specialty beverage.”

Dr. Sulik has been instrumental in the development of integrated care clinics in Minnesota, and since 2014 has been the chief integration officer of the Prairie Care Institute. Research indicates that integrating psychiatry and pediatric clinics improves outcomes in mental health conditions and chronic medical illnesses, while lowering the financial burden system-wide. The tenants of a successful collaborative care practice include education and training of pediatricians, using technology to improve screening and access to care, involving care-coordinators in pre- and post-visits, and having “coach therapists” to implement brief psychotherapy. Dr. Sulik maintained that psychiatrists are experts in leading patients through the process of change, and thus are uniquely poised to help organizations manage the adjustment to integration.

Eyal Shemesh, MD, of Mount Sinai Medical Center, next presented, “Screening for Mental Health Disorders in Pediatric Care Settings,” in which he argued against routine screening for depression and anxiety in pediatric practices. He pointed out that screening tools for depression and anxiety have a limited evidence base, as there are no randomized-controlled studies of improved outcomes of screening non-referred patients. He suggested that screening measures rely on the rater being aware of the child’s symptoms, thus diagnosis and referral for treatment only become available to parents and children who believe that there is a problem, and would have sought help regardless. Furthermore, there is a significant placebo effect when medications are successful in treating depression in children, and as such treatment may not be as effective for those who do not believe that they are in need of intervention. Dr. Shemesh discussed his own randomized controlled study in a pediatric food allergy clinic in New York City, in which screening for anxiety was performed during half of the clinic days. He found that screening did not enhance mental health follow-up, and those families who did follow-up with mental health providers had a better quality of life at baseline, and were arguably less in need of mental health services. Screening is not risk-free, as it can lead to false-positives and unnecessary referrals to already overbooked child and adolescent psychiatrists. Dr. Shemesh’s thought-provoking presentation stirred up a lively discussion during the question period.

Beth A. Smith, MD, chief of the Child and Adolescent Psychiatry Division at SUNY Buffalo, encouraged routine screening for patients with Cystic Fibrosis (CF) in her presentation: “Screening and Treating for Depression and Anxiety in Cystic Fibrosis.” Literature indicates that anxiety and depression lead to worse outcomes in CF by increasing inflammation, as well as by contributing to poor adherence and missed appointments. It is crucial for children to be adequately treated for depression and anxiety, and the first step is identification through screening. The Cystic Fibrosis Foundation and the European Cystic Fibrosis Society collaborated to form the International Committee on Mental Health in Cystic Fibrosis, which established guidelines for screening depression and anxiety, and provided a stepped-care model for treatment based on symptom severity. Targeting CF patients is a unique opportunity to assess physical health outcomes when depression and anxiety are addressed, as the CF database provides a record of specific outcomes, such as pulmonary function tests and body mass index. Detailed records of improved outcomes may serve as an incentive for CF treatment centers to be diligent in their screening.

Natalie Jacobowski, MD, a child and adolescent psychiatrist currently completing a Pediatric Palliative Care Fellowship, provided a hopeful view of collaboration with another pediatric subspecialty in her presentation, “Pediatric Palliative Care and Child and...”
Adolescent Psychiatry.” She discussed her experience working with the pediatric palliative care team at the Children’s Hospital of Philadelphia. Though psychiatry and palliative care each have their own roles to play, there are many overlapping areas of expertise, including providing emotional support, care coordination, and addressing bereavement. Child and adolescent psychiatrists bring a unique perspective to family and individual dynamics, which supports the work of the palliative care physician. Dr. Jacobowski made a powerful argument for continuing to improve collaboration between the two specialties in the service of the patient.

Taken together, the speakers at this symposium illustrated the importance of pediatricians and psychiatrists having access to one another to facilitate patient referrals, and to learn from each other’s expertise. Research demonstrates that adequate treatment of depression and anxiety improves outcomes in children with severe medical illness. Screening all patients for depression poses a problem, in part, because there are not enough child and adolescent psychiatrists to treat everyone who screens positive. Integrated care clinics help improve access to psychiatry, and reduce the stigma patients may feel when going to a specialized psychiatry clinic. There are real challenges in the development of collocated clinics in the form of both financial and structural barriers. As Dr. Sulik pointed out, psychiatrists have a distinctive skill set that can help lead institutions through the process of change.

As a fourth year general psychiatry resident in the process of applying for a fellowship in child and adolescent psychiatry, I am interested in integrated care as a means to address the long wait times children often endure to see a psychiatrist. I was excited to attend this year’s symposium. The passion of these five speakers made me honored to be entering a field in which there is so much work to be done, and so much opportunity to improve outcomes.

Dr. McLeod is a fourth year general psychiatry resident at the State University of New York at Buffalo. She may be reached at mmcleod3@buffalo.edu.

Get in the News!

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

Categories for submission and consideration are:

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

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

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

- For a list of column coordinators for Diversity and Culture, Ethics, Acute Care, Clinical Case Reports and Vignettes, Systems of Care, Psychotherapy, and International Relations email pjjutz@mac.com.

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

- **Features**, 600-1200 words
  - Interviews
  - Discussions of movies or literature
  - Creative Arts, e.g. poems, cartoons, drawings (limited to 1 page)
13% of youth ages 8-15 have a mental illness severe enough to cause significant impairment in day-to-day living.

79% of children ages 6-17 with mental illnesses do not receive treatment.

50% of all lifetime cases of mental illness are diagnosed by age 14.

Nearly 50% of students age 14+ with mental illness drop out of high school (the highest rate of any disability group).

More than 4,600 youth die by suicide annually, yet experts believe nearly 80% are preventable.

Studies indicate on average the delay between first onset of symptoms and treatment is 8 to 10 years.

JOIN US ON OUR BIKE RIDE ACROSS THE NATION AND HELP US BREAK THE CYCLE OF CHILDREN’S MENTAL ILLNESSES

Children's mental illnesses are REAL, COMMON, and TREATABLE. Yet today in the United States, this vulnerable population is caught in a vicious cycle of limited access to care, delayed treatment, and worsening illnesses.

Join us on our ride to Break the Cycle, raising awareness and support to (1) fund new research initiatives, (2) increase the number of child and adolescent psychiatrists, and (3) help ensure that children suffering in silence get the treatment they need.

Visit BREAKTHECYCLE.AACAP.ORG and make a donation, take the pledge, or sign up to be a rider.
AACAP’s 64th Annual Meeting takes place October 23-28, 2017, at the Washington Marriott Wardman Park and Omni Shoreham in Washington, DC. Abstract proposals are prerequisites for acceptance for all presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

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

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

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

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For questions about Module 13 or maintenance of certification, please contact Quentin Bernhard III, CME Manager, at 202.587.9675 or at qbernhard@aacap.org.
Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care
Edited by Kristen L. Eckstrand and Jesse M. Ehrenfeld
Springer 2016
Hardback: 483 pages- $149.00
eBook: 483 pages- $109.00

Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care is the second major text on LGBT health-care in the United States. As the editors state in the preface, “The purpose of this book is to serve as a guide for LGBT preventive and specialty medicine that can be utilized within health professions’ education from students, residents, and healthcare practitioners.”

The book contains 25 chapters organized into six parts. Each chapter is comprehensive in its review and offers valuable resources and extensive references.

Part I: The LGBT Population and Health provides an introduction to LGBT communities and broad issues related to health and access to care.

Part II: The LGBT-Inclusive Clinical Encounter discusses practical considerations, including clinic intakes, appropriate medical history, and how to use electronic health records in the care of LGBT patients.

Part III: LGBT Preventative Health and Screening considers primary care, prevention, coordination of care, LGBT parenting, and intimate partner violence.

Part IV: LGBT Health in Specialty Medicine considers pediatric and adolescent LGBT health, including subsections on mental health. The chapter has extensive supplements, including helpful books, videos, organizations, and hotlines for young patients and their families, guidelines for making health-care settings safer for LGBT youth, and key points for anticipatory guidance organized by age groups. Other specialty sections include adult and geriatric mental health, sexually transmitted infections, dermatology, urology, and OB/GYN.

Part V: Transgender Health considers interdisciplinary care, medical transition, surgical treatments, and facial feminization surgery. There is also an extensive chapter on adult mental health.

Part VI: Emerging Topics in LGBT Medicine explores internal issues, sex development and intersex populations, legal issues and policy, and common health questions. Three valuable appendices are included at the end of the book: chapter learning objectives, glossary of terms, and resource lists and position statements.

Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care is an ambitious work and represents a milestone in LGBT healthcare in the United States. While broad in its scope, child and adolescent psychiatrists will find this a valuable resource, particularly the sections on pediatric and adolescent health.
Missing Mommy
Written by Diane Kaufman, Illustrations by Hadley Hutton
CreateSpace Independent Publishing Platform 2016
Paperback: 483 pages- $12.50

Inspired by her work as a child and adolescent psychiatrist, Diane Kaufman presents the moving story of a young girl Layla, who longs for her mother, who was murdered by her father. Layla dreams that she flies to see her mother. Upon seeing her, Layla is comforted by her mother’s love and warmth. Layla shares her experience with her grandmother whom, in her wisdom, teaches Layla about the mysteries of the world and the transforming power of love. Missing Mommy is a beautifully written and gorgeously illustrated story of love, loss, and healing.
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Email Samantha Phillips, AACAP Communications Coordinator, at sphillips@aacap.org today.
AACAP Policy Statement

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
WWW.AACAP.ORG

Jurisdiction of the Juvenile Court System

Approved by Council on October, 2016

Neuroscience research has established that brain development continues throughout adolescence and into the early to mid-twenties. The frontal lobes, responsible for thinking, planning, judgment and inhibiting impulsive behavior, are the last areas to develop.¹ The scientific consensus on brain development has been recognized and cited by the U.S. Supreme Court in recent majority opinions concerning the juvenile death penalty (2005)² and juvenile life without parole (2010,³ 2012,⁴ and 2016⁵). Consistent with these decisions, individual states have begun to reevaluate and revise existing statutes pertaining to the jurisdiction of the juvenile court system. For most crimes, legislatures are increasingly raising the age at which young people can be tried as adults to 18.⁶ In addition to acknowledging the brain science, these lawmakers have noted the rehabilitative emphasis of the juvenile court system. The American Academy of Child and Adolescent Psychiatry supports and encourages this trend. The Academy specifically believes that defendants under the age of 18 should be adjudicated through the juvenile court system.

Developed by the Children and the Law Committee


For more information or to review AACAP’s Policy Statements visit www.aacap.org.
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.

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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
Development at AACAP

Steven Cuffe, MD, and G. Davis Gammon, MD
Co-Chairs, AACAP Development Committee

This is the first of periodic news articles describing the activities of the Development Committee and the Development Department at AACAP, and is based on a presentation that the co-chairs of the Development Committee, Steve Cuffe, MD, and Davis Gammon, MD, made at the Assembly of Regional Organizations of Child and Adolescent Psychiatry meeting in New York City October 22, 2016.

Few AACAP members know much about the activities of the Development Team (Development Department and the Development Committee) at AACAP, and yet the activities of the Development Team have typically produced 8 to 16% of AACAP’s income over the last 10 years. The Campaign for America’s Kids, for example, has invested nearly $1.1 million in AACAP fellowships, travel awards, and research and has impacted the careers of more than 190 medical students, residents, and junior scholars.

Development is a critically important activity in any nonprofit organization, since, through its activities, it produces a steady flow of income and investment to support the activities of the organization. The role of development at AACAP is no exception and it includes:

- The development of relationships with foundations, corporations, and philanthropists who share a commitment to improving the mental health of children, adolescents, and their families and solicitation of their support.
- Outreach to inform and educate to AACAP members and the AACAP “family” of the many important activities at AACAP that receive critical financial support from development.
- Long-range and strategic planning to advance these activities, ensure their success, and ensure AACAP’s growth and financial health in the future.

For many years, development income had been relatively stable, but recently development income for funding AACAP priorities has been shrinking. For example, funding from the pharmaceutical industry decreased by 73% between 2008 and 2016. This represents a $737,000 decrease in funding. Important AACAP activities that received development income have been affected negatively. Travel grants, early career investigator awards, and other activities have been curtailed. While some of the shortfall has been made up from operating funds derived from members’ dues, funding from dues is linear and will not replace this revenue over the long run.

For this reason, the AACAP Development Team has recognized it must intensify its outreach activities to AACAP members, the AACAP “family,” and other potential donors. Part of this effort is to educate our members about the needs we have to keep vital initiatives afloat, and to change how we, as members, view AACAP. We are not just a membership association. We are also an important part of the field of child and adolescent psychiatry, and an important part of improving the lives of children. As such, we are asking members to think not only of what value you receive from your membership in AACAP, but also about how you can impact the field through your charitable donations. Make AACAP a part of your personal philanthropy.

If you were able to attend the opening plenary session at the Annual Meeting, you were inspired by Lisa Yang, the recipient of the AACAP Catchers in the Rye Humanitarian Award. She urged us all to become leaders and change agents, to work to change the future for children for the better. She ended by presenting a check for $100,000 to AACAP. She did this, in her words, “As a gesture of MY personal commitment to support the mission of AACAP to research, treat and improve the lives of children and young adults with mental illness, I am initiating a circle of empowerment NOW.”

The AACAP Development Team shares this goal. We are actively engaged with AACAP staff in developing new strategies to improve development income to ensure the many important activities in support of the mental health of children and their families continue and expand. Critical to the success of these activities will be changes in the attitudes of the membership toward the support of AACAP’s activities. Dues are sufficient to support core organizational functions, while contributions from the membership will be increasingly important in ensuring AACAP’s financial health and expansion of its many worthwhile training and education programs. Potential corporate, foundation, and individual donors are more likely to support these activities if they see our membership providing enthusiastic support for them.

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Within this new “culture of giving,” members will receive support and encouragement in approaching potential donors and in soliciting gifts from them, as well. The Development Committee, in consultation with the AACAP leadership and its executive director, is reinvigorating the Campaign for America’s Kids (CFAK). The campaign was created in 2002, and has been a principal vehicle for raising development funds from charitable sources.

CFAK will become the vehicle through which all charitable gifts will be funneled. Donors may choose how CFAK will direct their gifts, whether in support of research, training, or other important AACAP activities. Other exciting projects, such as Break-the-Cycle and the 1953 Society will have their home within CFAK.

More information is available on the AACAP website about these activities, as is information about how to donate to CFAK. You can learn more by visiting www.aacap.org/AACAP/Donate. We hope you will, like us, be inspired by Lisa Yang, and join our “circle of empowerment.” As she said, the time is NOW to create a movement for change!

AAACP Catchers in the Rye Humanitarian Award

Deadline March 14, 2017

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

The AACAP Catcher in the Rye Humanitarian Award recipient will be recognized for their impact on children’s mental health at the 64th AACAP Annual Meeting, October 23-28, 2017, Washington, DC. Recipients are required to attend the awards ceremony at the Annual Meeting.

All nominations must be submitted to the AACAP Development Office via email at development@aacap.org. Nominations must be in a Word document or PDF. Please write “AACAP 2017 Humanitarian Award Nomination” in the subject line of the email.

Humanitarian Award Nominees:

- Only AACAP members may submit nominations
- Only non-AACAP-members are eligible to receive the award
- Nominees from the Washington, DC & Metro area are encouraged

Please submit the following information with the nomination:

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

If you have questions about the award or the award process, please contact Alan Mark Ezagui, MHCA, AACAP Deputy Director of Development at 202.966.7300 ext. 130 or aezagui@aacap.org.
Interview with Lisa Yang, 2016 AACAP Catchers in the Rye Humanitarian Award Recipient

Do you have any advice for others who are considering supporting the field of children’s mental health?

Mental illness has become a scourge of modern life. The World Health Organization estimates there are up to 500 million people affected by mental illness worldwide. Mental illness exists along the whole continuum of life: from autism and intellectual disability in childhood, through to depression, anxiety, bipolar disorder, schizophrenia, substance abuse, and psychosis in young adulthood; and toward the end of life, possibly dementia. In reality, it is impossible today not to know someone who is not affected by mental illness, whether family member, neighbor, friend, colleague, stranger, or well-known public figure. The condition could be permanent or temporary, genetic, inherited, acquired through trauma, overt or hidden. But whatever form it takes, the collective economic, social, and psychological burden on the individual, family, and society is immense.

The World Health Organization also uses a metric called DALY (Disability Adjusted Life Years) as a measure on the overall impact of a health condition both on life expectancy as well as on the quality of life. Using this metric, mental illnesses rank amongst the leading causes of disability globally.

Evidence shows that mental illness starts very early in life: 50% of those affected will have onset by age 14, 75% by age 24. There are over 38,000 suicides each year in the United States – one every 15 minutes, and is the third most common cause of death amongst people between the ages of 15 and 25, twice as common as homicide, and more common as a source of death than traffic fatalities.

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

Research based on scientific study of the brain is important. Thomas Insel, MD, a neuroscientist and psychiatrist and former Director of the National Institute of Mental Health, has advocated to reframe the view of mental illness as “brain disorders” rather than “mental disorders.”

From the work of Judith Rappaport, MD, and her colleagues at the same Institute, in which they studied children with very early onset schizophrenia over a period of 5 years, they found a profound loss of cortical gray matter. But, actually the subjects crossed a brain threshold much earlier, not at 20 or 22, when a diagnosis is confirmed, but at 15 or 16, with no change in behavior at that earlier point. Behavior, apparently, is the last thing to change. What that implies is that early detection, coupled with early intervention, is crucial as there are tools now that can detect these changes in the brain at a much earlier age, long before the symptoms emerge, as well as identify the predictable pattern of circuitry in the brain.

Research needs to be collaborative and done on a more varied and diverse population basis with global consideration of ethnic, economic, socio-cultural, and gender factors. This research then needs to be effectively pushed out and applied in its execution.

Can you share what inspired you to focus on mental health and disability?

My journey in life truly began 30-some years ago, with the reality of autism in my family, when two of my three children were born on the Spectrum. We had no family support system so we had to create our own ecosystem, taking little steps, a lot of them painful, some of them wild and experimental.

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This self discovery, initially driven by selfish motives, created engagement and eventually morphed into a passion to instigate change to improve the quality of care, and most importantly, meaningful employment and lives for individuals with brain disorders.

My focus has always been on the invisible disability that is not obvious. It has always been very disappointing to see how the disabled population has been discriminated against, their treatment lacking, and the funding always inadequate. Even with the public and private economic and structural supports, the efficacy and effectiveness has always been short of ideal. Not only in terms of the residential and living communities, but the lack of appropriate employment opportunities and work place supports is the result of the inability of the regulatory authorities to enforce, and companies to circumvent existing legal and regulatory requirements. Moreover, the neuro-typical population has yet to truly understand how to embrace, and maximize, the unique gifts and potential of those who are disabled.

You mention leadership is about changing the world, one person at a time. You also said one is a leader if one questions the status quo and works to shape the future for the better. These are important values to live by. How do we inspire others to apply your leadership principles to children’s mental health?

Do we truly realize when we have made an impact on others? We can all be leaders and change agents: we just need followers to create a movement for change. What I see is so much larger than all of us individually; it will take all of us pulling together to be part of the solution.

Early intervention is possible only by the ability to extend the reach of the specialists in the field.

Interventions are lacking because of the acute shortage of mental illness professionals, and especially access to care for children with mental illnesses.

I cite one model advocated by Vikram Patel, a global mental health care advocate and psychiatrist by training. He proposes a task shifting model that goes by the acronym SUNDAR:

- S Simplify message
- UN Unpack treatment
- D Deliver where needed
- A Affordable and Available
- R Reallocate

His model unpacks complex health care interventions into smaller components that can be more easily transferred to lesser-trained individuals in order to maximize delivery of affordable health care in local communities. Thus, the few specialists that exist can focus on the tasks of capacity building and supervision.

What did it mean to you to attend the AACAP award presentation in NYC?

I was deeply touched and humbled by the recognition accorded to me by AACAP. The members of AACAP have truly distinguished themselves as individuals who care by their choice of profession and field.

The opportunity to speak at The Plenary in New York City allowed me to share my personal story and the subsequent discovery of what was truly important to me, and, ultimately, the value I could bring to this conversation.

You made an extraordinary gesture by presenting AACAP with a check for $100,000. This was the first time a Humanitarian Award recipient has done this, and it is the single largest donation given to AACAP by an individual who is not a child and adolescent psychiatrist. In making this donation, you said you want it to initiate a “circle of empowerment.” Can you talk about this more, and how can AACAP honor your request that we build on this “circle”?

On October 26, 2016, I initiated a “circle of empowerment” at AACAP. I would like this circle to be an endowment applied toward “The Marilyn B. Benoit Fellowship” in honor of a past President of AACAP, Marilyn B. Benoit, MD. Dr. Benoit personifies the quintessential compassionate mental health professional who couples medical and technical competency with a human understanding of the granular complexity of young lives beset by trauma. She is forever a curious investigator, a humble educator, an honest and willing mentor, and most importantly, a do-er!

I hope that others will enlarge this circle financially to recognize the focus in the area of investigation of early childhood abuse, prevention and early intervention, and the importance of trauma-informed care, including therapeutic foster care, to ameliorate lifelong impairment.
FOR YOUR INFORMATION

A national initiative to improve the lives of children with mental illnesses

Did You Know?
Since 2008, CFAK has:

1. Invested nearly $1.1M in AACAP fellowships, travel awards, and research
2. Impacted the careers of more than 190 medical students, residents, and junior scholars
3. Approved 72% of all funds requested

FOR YOUR INFORMATION


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

Justin Key
Summer Medical Student Fellowship, 2014

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

Stephanie Ameis, MD
Pilot Research Grantee, 2015

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

Elizabeth Brannan
Educational Outreach Program Recipient, 2014

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Thank You for Supporting AACAP!

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

Gifts Received November 1, 2016 to December 31, 2016

<table>
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Susan Mendik |
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Paramjit T. Joshi, MD

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.
Distinguished Member Awards

Deadline: May 2, 2017

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

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

All Distinguished Member and Service Awards are conferred through a nomination process. Distinguished Member and Service Award recipients will be recognized at the Distinguished Members Awards Luncheon and will give an Honors Presentation regarding their work at AACAP’s 64th Annual Meeting, October 23-28, 2017 in Washington, DC.

AACAP Cancro Academic Leadership Award
AACAP’s Cancro Academic Leadership Award for master teachers, which is offered in odd-numbered years, recognizes individuals who have made outstanding contributions to child and adolescent psychiatry education. This award offers a $2,000 honorarium to the award recipient. The award recipient will receive a plaque and will be recognized at AACAP’s 64th Annual Meeting in Washington, DC.

AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities
This award recognizes a child and adolescent psychiatrist and Academy member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with developmental disabilities. These contributions must have national and/or international stature and clearly demonstrate lasting effects. The contributions may be in areas of teaching, research, program development, direct clinical service, advocacy or administrative commitment. A cash prize of up to $1,000 will be awarded. Nomination letters must be accompanied by a CV for the individual nominated. The award winner will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during AACAP’s 64th Annual Meeting in Washington, DC.

AACAP Irving Philips Award for Prevention
This award recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents. These contributions must have national and/or international stature and clearly demonstrate lasting effects. The contributions may be in the areas of teaching, research, program development, direct clinical service, advocacy or administrative commitment. The award pays $2,500 to the winner and a $2,000 donation to a prevention program or center of the awardee’s choice. Nomination letters must be accompanied by a CV for the individual nominated. The award winner will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during AACAP’s 64th Annual Meeting in Washington, DC.

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

AACAP Simon Wile Leadership in Consultation Award, supported by the Child Psychiatry Service at Massachusetts General Hospital
This award acknowledges outstanding leadership and continuous contributions in the field of consultation-liaison child and adolescent psychiatry. The $1,000 award is named after Simon Wile, MD, a renowned pediatrician and a life-long supporter of child and adolescent psychiatry. Nomination letters must be accompanied by a CV for the individual nominated. The awardee will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during AACAP’s 64th Annual Meeting in Washington, DC.

AACAP Rieger Psychodynamic Psychotherapy Award
This award recognizes the best published or unpublished paper, written by an AACAP member, that uses a psychodynamic framework and presents: 1) clinical material demonstrating the inner life of an infant, child or adolescent or 2) research material that promotes psychodynamic principles in order to illustrate the paper’s idea or hypothesis. The paper should include consideration of a DSM diagnosis and a focused literature review that includes current psychiatric literature. The material for this paper may be drawn from clinical practice or from clinical research. The recipient will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during AACAP’s 64th Annual Meeting in Washington, DC.

AACAP Norbert and Charlotte Rieger Service Program Award for Excellence
This award recognizes innovative programs that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents, and serve as model programs to the community. This award of $4,500 is shared among the awardee and his or her service program. Nomination letters must be accompanied by a CV and any support materials for the individual or organization nominated. The recipient will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during AACAP’s 64th Annual Meeting in Washington, DC.

AACAP Sidney Berman Award for the School-Based Study and Treatment of Learning Disorders and Mental Illness
This award recognizes an individual or program that has shown outstanding achievement in the school-based study or delivery of intervention for learning disorders and mental illness. A cash prize of $4,500 will be awarded. Nomination letters must be accompanied by a CV for the individual nominated and program information. The awardee will be recognized at a Distinguished Awards Luncheon and make an Honors Presentation about his or her work during AACAP’s 64th Annual Meeting in Washington, DC.

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

**CLASSIFIEDS**

**DISTRICT OF COLUMBIA
CHIEF, DIVISION OF PSYCHIATRY AND BEHAVIORAL SCIENCES**
Children’s National Health System (CNHS) in Washington, D.C. invites applicants for the position of Chief and Endowed Professor of the Division of Psychiatry and Behavioral Medicine. We are looking for a dynamic leader who will build on the rich tradition of world-class psychiatric care at Children’s National and develop innovative care and research models to meet the challenges ahead. CNHS is a nationally, highly-ranked children’s hospital. Children’s National’s mission is to excel in clinical care, advocacy, research, and education. We improve health outcomes for children and lead in the creation of innovative solutions to pediatric health challenges. The primary clinical facilities of the Division of Psychiatry and Behavioral Medicine are housed in the newly renovated, state of the art Child and Adolescent Psychiatry Inpatient Units and the recently renovated, on-site outpatient clinic. The Division operates outpatient programs in Washington, D.C., Montgomery County, Maryland, and in Northern Virginia. The Division has imbedded outpatient services in Children’s National primary care clinics. It has an ACGME-approved Child Psychiatry fellowship and has 14 faculty members. The Chief will be academically appointed at The George Washington University. Applicants for this position should possess an M.D. degree or both M.D. and Ph.D. degrees, certification in psychiatry by the ABPN and meet requirements for appointment as associate or full professor. Candidates must be eligible for a medical license in Washington, D.C. Candidates should have a strong record of scholarly activity, and preferably, a stellar record of sustained extramural funding. We expect the successful candidate to possess clinical expertise and leadership abilities, with solid experience in administering psychiatric inpatient and outpatient clinical services. The candidate must have good interpersonal skills, and be able to work cooperatively and congenially within a diverse group of academic, clinical, and philanthropy leaders. Candidates with a vision for enhancing and transforming the clinical and academic activities of a multi-disciplinary department are especially encouraged to submit applications. Children’s National Health System is an equal opportunity employer that evaluates qualified applicants without regard to race, color, national origin, religion, sex, age, marital status, disability, veteran status, sexual orientation, gender, identity, or other characteristics protected by law.

Interested applicants should submit a letter of interest and curriculum vitae by March 15, 2017 to: Jocelyn Villongco, Director, Center for Neuroscience and Behavioral Medicine, Children’s National Health System, 111 Michigan Avenue, N.W., Washington, DC 20010 or by email to jvillong@childrensnational.org. Any inquiries about the position can be directed to: Roger J. Packer, M.D., Senior Vice President, Center for Neuroscience and Behavioral Medicine, at rpacker@childrensnational.org or by calling (202) 476-5973.

**Company:** Children’s National Health System (1015690)
**Job ID:** 8705345
**jobsource.aacap.org/jobs/8705345**

**MISSOURI**

**COME GROW WITH MERCY KIDS- GN ON BONUS AND FELLOWSHIP STIPEND AVAILABLE**
Come grow with Mercy Kids. Child and Adolescent Psychiatrists Positions in Missouri and New Orleans SIGN ON BONUS and FELLOWSHIP STIPEND AVAILABLE Mercy Clinic is seeking full-time BE/BC Child and Adolescent Psychiatrists to join our established group practices located at Mercy Children’s Hospital in St. Louis, Mercy Hospital Jefferson in Festus, Missouri and Mercy Family Center in New Orleans. Opportunities: Mercy Children’s Hospital St. Louis is seeking a Child and Adolescent Psychiatrist to join a practice with five Board-Certified Child and Adolescent Psychiatrists delivering inpatient and outpatient services. Mercy Hospital is the largest child and adolescent psychiatry group in Missouri with 175 pediatric providers on staff with over 80 fellowship-trained pediatric specialists Mercy Hospital Jefferson in Festus, Missouri is a 251-bed acute care facility and is 30 minutes south of St. Louis. Primary responsibilities will be to set up clinic services – both outpatient practice and IOP program. Mercy Family Center in New Orleans is seeking a Child and Adolescent Psychiatrist to join an established group practice located at our Metairie clinic. Mercy Family Center is a multi-disciplinary outpatient behavioral health clinic comprised of 20 full time employees serving nearly 3,000 families. This Position Offers: Integrated health system with a competitive income guarantee. Comprehensive benefits including health, dental, vision and CME. Relocation assistance and professional liability coverage. System-wide EPIC EMR. Sponsorship of H1B Visa.

For more information, please contact: Lisa Hauck, MBA | Senior Physician Recruiter 314-364-3840 | fax: 314-364-2597 lisa.hauck@mercy.net | mercyfamilycenter.com. EOE/AA/Minorities/Females/Disabled/Veterans Employer

**Company:** Mercy (883968)
**Job ID:** 8509304
**jobsource.aacap.org/jobs/8509304**

**NEW JERSEY**

**RWJBARNABAS HEALTH SEEKING EATING DISORDERS SPECIALIST**
RWJ Barnabas Health is Seeking Child and Adolescent Psychiatrist specializing in Eating Disorders. RWJ Barnabas is seeking board-certified Child and Adolescent Psychiatrist who specializes in eating disorders for a new position with the RWJBarnabas Health Behavioral Health Network. As the largest behavioral health network and the largest integrated health system in NJ, RWJBarnabas Health offers competitive compensation to physicians...
with strong base salary plus additional compensation for call AND quality-based bonus incentives. RWJBarnabas Health psychiatrists also receive a robust benefits package including: Health insurance Malpractice (with tail) 401k with company match, 5 days off for CME Budget for CME 31 Paid Time Off (PTO days) Budget for licensing, books, association fees, etc. For information or to apply for these or additional opportunities with RWJBarnabas Health, please contact Annelise Catanzaro, Manager of Physician Development at (973) 322-4364 or by email: annelise.catanzaro@rwjbh.org.

Job Requirements:
Board-Certification in Child and Adolescent Psychiatry Licensed or Eligible for Licensure in New Jersey

Company: Barnabas Health (886156) Job ID: 8640208 jobsourcing.aacap.org/jobs/8640208

NORTH CAROLINA

FACULTY APPOINTMENT – CHILD/ ADOLESCENT PSYCHIATRIST

FACULTY APPOINTMENT – CHILD/ ADOLESCENT PSYCHIATRIST
DIVISION OF CHILD AND FAMILY MENTAL HEALTH AND DEVELOPMENTAL NEUROSCIENCE
DUKE UNIVERSITY, DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES DURHAM, NORTH CAROLINA

The Department of Psychiatry and Behavioral Sciences at the Duke University School of Medicine invites applications for board-certified/ board-eligible Child and Adolescent Psychiatrists to support several clinical programs, including inpatient and outpatient Consult Liaison services, general outpatient clinics, autism services, and the development of integrated programs. We are seeking individuals who are interested in working with a growing team of clinicians, researchers, and educators with the goal of enhancing the range and scope of clinical services provided to children and families. The attending Child and Adolescent Psychiatrist will be responsible for direct clinical care and teaching and mentoring medical students, general psychiatry residents, and child and adolescent psychiatry fellows. This position is a faculty appointment with rank commensurate with the applicant’s experience. We are seeking both early career applicants and those interested in a senior leadership opportunity. Primary Activities: This clinical faculty position will include participating in individual- and team-based clinical activities focused on children and families with a range of psychiatric and disorders. Clinical responsibilities will include participation in medical and interdisciplinary evaluations and intervention with children presenting with a wide array of needs. The position also will involve supervision of medical students, general psychiatry residents, and child and adolescent psychiatry fellows, as well as the provision of in-service trainings. Scholarly activities are encouraged and supported. About Duke: Duke University offers a rich intellectual and scientific environment facilitated by several institutes, including the Duke Institute for Brain Sciences and the Duke Clinical Research Institute, which are designed to promote interdisciplinary research. According to U.S. News and World Report, Duke University Hospital was ranked #1 in North Carolina, and #1 in the Raleigh-Durham region for the 16th consecutive year. As the Southeast’s preeminent health care provider, Duke University Health System attracted more than 66,000 inpatient stays and more than 2 million outpatient visits in FY16. Duke Health encompasses one of the largest biomedical research enterprises in the country, with more than $650 million annually in sponsored research expenditures. Duke employees are part of a premier organization dedicated to excellence in education, research, and patient care. Duke’s overall benefit plan has long been recognized and valued because of its comprehensiveness and competitiveness in the market. In addition to a robust array of traditional benefits such as health care, dental care and retirement, Duke also offers a wide range of family-friendly and cultural benefits to attract, support and reward the skilled employees that help Duke remain a premier education, research and health care institution. Duke is located in Durham, NC (www.durham-nc.com), a creative, innovative community that is a nexus for learning, research, and industry. Durham was listed as one of the best places to visit by Travel and Leisure Magazine in 2015 because of the numerous cultural, culinary, and outdoor activities offered in the area. Durham is part of the larger Research Triangle area that includes the University of North Carolina at Chapel Hill, North Carolina State University, numerous biotechnology, government, and other enterprises. Application: Applicants for the position should send the following: Current curriculum vita Names and contact information for three references Direct questions to: Gary Maslow, MD, MPH, Co-Chief, Medical Director; gary.maslow@duke.edu Kendra Rosa, MPH, Division Administrator; kendra.rosa@duke.edu

Job Requirements:
Candidates must be eligible for licensure in the state of North Carolina and be board-certified/board-eligible through the American Board of Child Psychiatry and Neurology.

Company: Duke University (1009957) Job ID: 8616044 jobsourcing.aacap.org/jobs/8616044

PENNSYLVANIA

ASSOCIATE MEDICAL DIRECTOR

The Associate Medical Director is responsible for providing administrative oversight of the physicians and clinical oversight of the program as well as department (DBHIDS) wide children’s programming in consultation with the Deputy Chief Medical Officer, Children’s services. The position provides leadership in the development and implementation of clinical policy and initiatives throughout the Department of Medical Affairs, clinical policy and initiatives throughout DBHIDS, engagement of cross-systems stakeholders for children’s services as well as support Child/Family Departmental grants. Essential Functions: Build and maintain a strong functional team through effective recruiting, training, performance management, coaching, team building and succession planning. Provide clinical
review of cases for medical necessity from multiple sites. Peer reviews cases where there is a disputed level of care. Supervise Assistant Medical Director, Children’s Services. Participate in clinical and administrative meetings. Engages cross-systems child service system stakeholders (local DHS, School District, Mayor’s office etc). Interact with providers both on clinical and administrative matters. Monitor physicians’ productivity and effectiveness in conducting peer utilization review with physician providers.

Job Requirements:
Education: Medical degree License/Certification: State license in the Commonwealth of Pennsylvania; Board Certification in Child and Adolescent Psychiatry Relevant Work Experience: Minimum of 5 years of experience in clinical psychiatry including inpatient care with a minimum of two years of administrative experience such as Psychiatric Unit Director Skills: Problem solving and strong analytical skills Excellent interpersonal skills Flexibility in assessing situations and evaluating needs Proficient in Microsoft Word and Excel Strong administrative and managerial skills Excellent verbal and communication skills Work Conditions (including travel, overtime required, physical requirements and occupational exposure): Must be able to travel within the City of Philadelphia. Regularly requires walking, standing, stooping, bending, sitting, reaching, pushing, pulling and/or repetitive wrist/hand movements for various lengths of time throughout the day. Ability to utilize computers and office equipment to complete daily work responsibilities. Regularly works inside in areas that are adequately lighted and ventilated. Some fluctuation in temperature. No protective equipment routinely needed. Must be able to adapt to continuous changes/demands of the job. What CBH Offers: Competitive compensation Growth opportunities Telecommute opportunities Comprehensive Medical, Dental, and Vision coverage Generous 403(b) Retirement Plan On-site Wellness Programs Tuition Reimbursement Generous Paid Time Off plan About CBH CBH is one of the nation’s largest managed care organizations specializing in meeting the behavioral health needs of Medicaid-eligible residents. CBH is a non-profit corporation, managed by the City of Philadelphia. It serves as a key component of the city’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), which provides an array of mental health and substance abuse services to adults, adolescents and children. CBH plans for and coordinates the delivery of covered services to the city’s uninsured, underinsured and Medicaid-eligible residents, in conjunction with the Philadelphia Office of Mental Health (OMH) and the Office of Addiction Services (OAS).

* Employees must establish and maintain Philadelphia residency within 1 year of employment Equal Employment Opportunity: CBH provides equal employment opportunities to all qualified individuals without regard to race, creed, color, religion, national origin, age, sex, marital status, gender identity, sexual orientation, individual genetic information or non-disqualifying physical or mental handicap or disability in each aspect of the human resources function. Americans with Disabilities Act: Applicants as well as employees who are or become disabled must be able to perform the essential job functions either unaided or with reasonable accommodation. CBH will determine reasonable accommodation on a case-by-case basis in accordance with applicable law. This job profile reflects management’s assignment of current duties, responsibilities, and essential functions; it does not prescribe all or restrict the tasks that may be assigned now, or in the future, relevant to the responsibilities for this position.

Community Behavioral Health (CBH) may change the specific job duties with or without prior notice based on the needs of the organization.

Company: Community Behavioral Health (890046)
Job ID: 8626271
jobsource.aacap.org/jobs/8626271

RHODE ISLAND
DIRECTOR, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
VICE CHAIR, DEPARTMENT OF PSYCHIATRY AND HUMAN BEHAVIOR, ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY

Lifespan and Hasbro/E.P. Bradley Hospitals and the Department of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University, Providence, RI, are seeking a full time Psychiatrist for Director, Division of Child and Adolescent Psychiatry and Vice Chair. The successful candidate must qualify for a full-time medical faculty academic appointment at the rank of Professor or Associate Professor, Research Scholar Track in the Department of Psychiatry and Human Behavior at the Warren Alpert Medical School of Brown University. Minimum requirements include: Doctor of Medicine Degree certified in Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology; eligible for Rhode Island Medical License; and have a distinguished national reputation for academic accomplishment in research, scholarship and teaching. Lifespan is an EEO/AA employer and encourages applications from minorities and women. Review of applicants will begin immediately and will continue until the position is filled or the search is closed. Please apply online at https://apply.interfolio.com/38187.
DOUGLAS B. HANSEN, MD,
42ND ANNUAL REVIEW COURSE
IN CHILD AND ADOLESCENT PSYCHIATRY
CO-CHAIRS:
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MARY MARGARET GLEASON, MD

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Questions? meetings@aacap.org

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