President’s Message: Making Our Voices Heard! • Gregory K. Fritz, MD......................65
Acute Care: Rapid Assessment of Risk for Physical Aggression: Is the BRACHA an Answer to Our Prayers for Safety? • Drew H. Barzman, MD................................. 68
Geek Minded Psychiatry: Introduction to Cosplay and Fanfiction • Dales Peeples, MD, and Jennifer Yen, MD.................................................................74
Honor Your Mentor .....................................................................................................78
Facts for Families: ADHD and the Brain ..................................................................92
Save the Dates!
New Research Poster Deadline: June 15, 2017
Preliminary Program and Hotel Reservations Available: June 15, 2017

AACAP's
64TH ANNUAL MEETING
OCTOBER 23–28, 2017
WASHINGTON, DC
Marriott Wardman Park & Omni Shoreham Hotels

Visit www.aacap.org/AnnualMeeting/2017 for the latest information!
<table>
<thead>
<tr>
<th>TABLE of CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COLUMNS</strong></td>
</tr>
<tr>
<td>Neera Ghaziuddin, MD, Section Editor • <a href="mailto:neerag@med.umich.edu">neerag@med.umich.edu</a></td>
</tr>
<tr>
<td>President’s Message: • Gregory K. Fritz, MD. ................................................................. 65</td>
</tr>
<tr>
<td>Guest Column: Consultation-Liaison Psychiatry and Motivational Interviewing: A Natural Marriage to Enhance Health Behavior Change Counseling in Integrated Care Settings • Nasuh Malas, MD, MPH .......................... 66</td>
</tr>
<tr>
<td>Acute Care: Rapid Assessment of Risk for Physical Aggression: Is the BRACHA an Answer to Our Prayers for Safety?  • Drew H. Barzman, MD. ........................................................................ 68</td>
</tr>
<tr>
<td>Diversity and Culture: International Medical Graduate Caucus • Balkozar S. Adam, MD. ........................................... 70</td>
</tr>
<tr>
<td><strong>COMMITTEES</strong></td>
</tr>
<tr>
<td>Ellen Heyneman, MD, Section Editor • <a href="mailto:eheyneman@uscd.edu">eheyneman@uscd.edu</a></td>
</tr>
<tr>
<td>Media Committee: Know Your Video Games? Your Patients Do! • Ashvin Sood and Paul Weigle, MD ......................... 72</td>
</tr>
<tr>
<td><strong>OPINIONS</strong></td>
</tr>
<tr>
<td>Harmony Raylen Abejuela, MD, Section Editor • <a href="mailto:harmonyraylen@hotmail.com">harmonyraylen@hotmail.com</a></td>
</tr>
<tr>
<td>Consumer Issues Committee and Media Committee: Geek Minded Psychiatry: Introduction to Cosplay and Fanfiction • Dales Peeples, MD, and Jennifer Yen, MD 74</td>
</tr>
<tr>
<td>Letter to the Editor • Kim J. Masters, MD. ........................................................................ 76</td>
</tr>
<tr>
<td><strong>HONOR YOUR MENTOR</strong></td>
</tr>
<tr>
<td>Jon (Jack) McClellan, MD, Section Editor • <a href="mailto:drjack@u.washington.edu">drjack@u.washington.edu</a></td>
</tr>
<tr>
<td>Honor Your Mentor. ........................................................................................................ 78</td>
</tr>
<tr>
<td><strong>MEETINGS</strong></td>
</tr>
<tr>
<td>Alvin Rosenfield, MD, Section Editor • <a href="mailto:arosen45@aol.com">arosen45@aol.com</a></td>
</tr>
<tr>
<td>Your Evaluations Matter! How AACAP Handles Member Reports of Bias • Eric Williams, MD, and R. Andrew Harper, MD. ........................................................................ 84</td>
</tr>
<tr>
<td>Highest Rated Scientific Sessions at AACAP’s 63rd Annual Meeting ................................................................. 85</td>
</tr>
<tr>
<td>New Research Poster Call for Papers. .................................................................................... 86</td>
</tr>
<tr>
<td><strong>FEATURES</strong></td>
</tr>
<tr>
<td>Media Page • Erik Loraas, MD .............................................................................................. 87</td>
</tr>
<tr>
<td>Where Dads Belong and How We Can Help Them Get There • Kyle D. Pruett, MD. ..................................................... 88</td>
</tr>
<tr>
<td><strong>FOR YOUR INFORMATION</strong></td>
</tr>
<tr>
<td>Membership Corner ........................................................................................................ 90</td>
</tr>
<tr>
<td>In Memoriam .................................................................................................................. 90</td>
</tr>
<tr>
<td>Thank You for Supporting AACAP! .................................................................................. 91</td>
</tr>
<tr>
<td>Facts for Families: ADHD and the Brain ........................................................................ 92</td>
</tr>
<tr>
<td>Policy Statement Procedures and Requirements ................................................................ 94</td>
</tr>
<tr>
<td>Classifieds ................................................................................................................... 96</td>
</tr>
</tbody>
</table>

Cover Photo: This photo was taken by me at the 2008 Inauguration on Pennsylvania Avenue in Washington, DC. This little patriot was a delightful subject! ~ Sheila Sontag, MD
MISSION STATEMENT
The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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

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

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

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

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

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

COUNCIL
Manal Assi, MD
Gabrielle A. Carlson, MD
Lisa M. Cullins, MD
Timothy F. Dugan, MD
Cathryn Galanter, MD
Shashank V. Joshi, MD
Debra E. Koss, MD
Douglas A. Kramer, MD
Melvin D. Oatis, MD
Karen Pierce, MD

EXECUTIVE DIRECTOR
Heidi Büttner Fordi, CAE

JOURNAL EDITOR
Andrés Martin, MD, MPH

PROGRAM COMMITTEE CHAIR
Boris Birmaher, MD

COLUMN COORDINATORS
Ayesha Mian, MD, mian@bcm.tmc.edu
International Relations
Jeffrey Hunt, MD, jhunt@lifespan.org
Clinical Case Reports and Vignettes
Sala S.N. Webb, MD, webbpsychiatric@gmail.com
Diversity and Culture
Arden Dingle, MD, adingle@emory.edu
Ethics
Rachel Ritvo, MD, rrzmd@comcast.net
Psychotherapy
Kim Masters, MD, mchanven@vistahill.org
Acute Care Psychiatry
Mark Chenven, MD, cjoy1@gmail.com
Systems of Care
Charles Joy, MD, crjoy1@gmail.com
Poetry

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

© 2017 The American Academy of Child and Adolescent Psychiatry, all rights reserved
PRESIDENT’S MESSAGE

Make Our Voices Heard!

Gregory K. Fritz, MD
President, AACAP

There are a lot of things I love about AACAP, but one of the things as president I’ve come to appreciate most is how readily we can pool our efforts and expertise, come to consensus on an issue, and take appropriate action. Nowhere has this been more apparent than in the decision process dealing with how to respond to current events. I’d like to share some of the details about our process and our thinking in those sorts of situations.

AACAP as an organization cannot weigh in on every controversy that engages our country. However, we do take a position on issues pertinent to children’s mental health, which can entail signing on to an amicus curiae brief, issuing a policy statement, or writing a letter to our membership. The process for developing a policy statement is well developed and clearly spelled out on p. 94 of this issue for individuals or components who are interested in creating one.

Often issues present with the need for a rapid response. This is usually the case with amicus curiae briefs and queries from journalists, and periodically for “hot issues” that arise. In such instances, AACAP’s goal is to be the collective voice of our membership and speak clearly, knowledgeably, and professionally to ensure that neither the welfare of our patients nor the expertise of child and adolescent psychiatrists is ignored.

Speaking for the membership is no easy task. It’s impossible to survey all the members on short notice; 9,200 AACAP members are not a homogeneous group in any respect except that we are all devoted to children and intent on improving their mental health. This central message is therefore the driving force behind our responses.

In crafting AACAP’s statement on the impact of the first executive order on immigration, I was especially pleased with our process and our product. Two days after the communication was released, I received an unusual email from Harriet Wolfe, MD, president of the American Psychoanalytic Association. She began by saying, “I found your statement from the AACAP well-written, compelling, and appropriate to what a mental health organization can say. It is a powerful statement.” She went on to ask about our process of creating such a statement and, from a governance point of view, how we were able to release it in such a timely manner. This interest was generated because her organization was apparently less nimble and decisive.

When it comes to time-sensitive communications that reflect AACAP’s positions and values, the responsibility rests with the AACAP executive committee and senior staff members, working rapidly by telephone and email. Input from experts within AACAP is sought as needed. In my experience, the creation of a communications document is always a consensus process, with all parties being involved in free and open discussion and suggesting edits. Ultimately, were consensus not to be achieved, the final decision would be made by a vote of the Executive Committee.

As a responsible professional organization, we will continue to craft well-balanced responses that reflect the rich diversity within our membership. Individual members are of course bound by no such constraint; when speaking of our personal values, we are free to be as opinionated as we choose – as long as we don’t purport to speak for AACAP.

As I’ve said countless times since becoming president, as child and adolescent psychiatrists, we need to make advocacy a real component of our professional identity. We, as a collective, need to be visible and loud – whether it is at the Federal level, within our home states and communities, with insurance companies and health plans, or in the media. This is why I strongly encourage you to attend AACAP’s Legislative Conference, May 11-12, 2017, in Washington, DC.

This is the perfect opportunity to learn how to become an effective advocate for our specialty and our patients, as you will partner with fellow members, trainees, families, and youth to promote child and adolescent psychiatry on Capitol Hill. For more information and to register for the event, visit AACAP’s website at www.aacap.org.

Now is the time for making our collective voice heard!
Behavior change is an innately human experience. We all know the feeling of being asked, pushed, cajoled, or even forced into engaging in a behavior that we may not be invested in pursuing. The experience can be frustrating and result in a mix of responses, weighted by our own perceptions of the incentives and disincentives to maintaining or changing a given behavior. In many of these situations, the result is a state of ambivalence, keeping us stuck in the status quo. Despite our awareness of this shared human experience, we often neglect this inherent understanding when conducting health behavior change counseling.

Motivational interviewing is a framework to empower patients and families to enact behavior change to improve their health and quality of life in a way that is feasible to them, enlists their own reasons for change, and validates their innate abilities and life experiences to fuel that change. We often are hard-wired to help others by “fixing them,” and this reflexive desire can be detrimental. The result can be overly directive, overly advising, and at times pathologic for the patient-clinician relationship. The traditional medical model often involves a preexisting understanding of the patient either being devoid of knowledge, skills, or the will to enact a behavior change. The pre-established dynamic is that the patient is in deficit and that clinicians must provide the patient with some resource to fill that void. The reality, however, is that most patients are already aware of the risks and benefits of their behaviors and alternative behaviors. Many have often attempted to change with variable success. Patients and families are constantly, either consciously or subconsciously, evaluating the pros and cons of the status quo.

Motivational interviewing is a departure from the traditional medical model. It takes the spotlight for health behavior change off of the clinician and refocuses that light onto the patient’s thoughts, understandings, emotions, and abilities. The push-pull of behavior change counseling is diminished and conversations become more of a dance, where you may miss a few steps, but the performance is fluid and moves with the partner in the process. Although having deep roots in substance use counseling, there has been an emergence of interest, research, and practice utilizing motivational interviewing to support patient-clinician interactions in pediatric healthcare. Motivational interviewing is flexible and adaptable with growing applications in diverse pediatric care settings, disease populations, countries, and languages. It can be utilized with patients and families, as well as other caregivers. Motivational interviewing has been coupled with other psychotherapeutic modalities and interventions. It has been used in distance-based counseling, and through computer-assisted applications. Given the tremendous utility of motivational interviewing, it is no surprise that it is being increasingly adopted and incorporated into practice with resulting cost reductions, improved clinical outcomes, reduced overutilization of healthcare resources, and improved quality of life for youth with chronic disease.

As motivational interviewing grows in its evidence-base, application, and dissemination, it can become a vehicle to fuel integrated care and interdisciplinary education. Consultation-liaison (C/L) psychiatry is uniquely positioned to embrace and implement motivational interviewing. Integrated care settings are ripe environments for nurturing, promoting, and educating our colleagues on the use of motivational interviewing.

In C/L psychiatry, many of the patients and families can be ambivalent about the myriad of decisions needed for care. The increased stress and complexity of providing care at the interface of physical medicine and psychiatry results in an inherent risk of the clinician developing an intense desire to “fix” the patient. Motivational interviewing is the vehicle to assist the clinician in partnering with the patient and family to elicit reasons for change and empower the patient and family to pursue that change. In the case example here (Figure 1), we see how motivational interviewing may be applied in an integrated care setting. Using the traditional model leads us down the clinician’s agenda of wanting to “fix” the problem of nonadherence. Early assumptions are made about the reasons for nonadherence and the means of addressing this behavior. As a result, the patient is somewhat less engaged and provides less information, resulting in the clinician overly focusing on a knowledge or skill gap. In the motivational interviewing approach, we see

“Motivational interviewing is a departure from the traditional medical model. It takes the spotlight for health behavior change off of the clinician and refocuses that light onto the patient’s thoughts, understandings, emotions, and abilities.”
the clinician partnering with the patient to better understand the experience and elicit from the patient their understanding, motivations, and potential challenges so as to set a mutual focus and partner in the process of addressing the patient’s nonadherence.

Motivational interviewing can aid in clarifying diagnostic concerns, understanding transference and countertransference issues, and enhancing patient understanding of their disease and treatment, as well as engaging patients, families, and consultees in the overall, comprehensive care of the patient. C/L psychiatry has the unique opportunity to foster and nurture the education and dissemination of motivational interviewing to enhance evidence-based, patient-centered health behavior change counseling that resonates with our own innate understandings of the human experience.

**Additional Reading**


**Figure 1: Motivational Interviewing – A Different Approach**

**Case Presentation:** An adolescent female presents to an integrated primary care clinic presenting with concerns relating to worsening asthma in the setting of medication nonadherence. She has been discharged from the hospital two weeks ago following an asthma exacerbation. This was her first hospitalization. The patient is accompanied by her mother in clinic today and you are seeing the patient jointly with her primary care physician.

The patient has a history of anxiety and ADHD, as well as being overweight and having eczema. She is maintained on a steady dose of methylphenidate product and sees a therapist weekly for cognitive behavioral therapy targeting anxiety. She has no other past psychiatric or medical history, and is developmentally appropriate with no learning difficulties. Family history is significant for anxiety in several family members. She lives with both of her biological parents, has no siblings, and is in the 10th grade with average school performance. She is active in soccer and band, but has noted difficulties with excessive coughing and shortness of breathe in soccer and needing to take frequent breaks in band due to shortness of breathe.

**Case scenario:** You have set aside 15 minutes to talk to the patient alone about her asthma and medication adherence.

**Clinician:** Thank you for taking the time to meet with me alone to discuss your asthma today. My understanding from your primary care doctor is that you were recently hospitalized for asthma. Can you tell me what happened?

**Patient:** I don’t know. I was doing fine. Then, a few weeks before I went to the hospital, I started to cough. It kept getting worse and I tried to use my inhaler but it wasn’t working.

**Traditional medical model:**

**Clinician:** How often were you taking your medications before you went to the hospital?

**Patient:** I miss it sometimes because I get busy, but it has never been a problem for me before.

**Clinician:** This time it was a problem and you became sick and had to go to the hospital. With a disease like asthma, you have to take your medications on time and as instructed by your primary care doctor. Can you tell me what medications you take and when you have to take them?

**Patient:** I have my rescue inhaler, the blue one, called albuterol. I take that one if I need to, like when I get a cough or start to get heavy breathing. I also am on singular (montelukast), which I take once a day and Advair (fluticasone/salmeterol), which I take twice a day.

**Clinician:** How much of the time are you missing a dose?

**Patient:** Maybe like once every other day, I just get busy and forget I guess, but it usually doesn’t bother me.

**Motivational interviewing approach:**

**Clinician:** You are really unsure as to why you had been feeling well and then started to have worsening breathing, eventually ending up in the hospital. This must have been a scary experience for you.

**Patient:** Yeah, I just couldn’t breathe and I was really starting to freak out. This has never happened before and I do not want this to happen again. I get nervous even thinking about it.

**Clinician:** This was such a horrible experience and not only did it effect how you felt physically, but it also mad you very anxious and upset. Were there other ways that your asthma getting worse and being in the hospital may have impacted you?

**Patient:** Well, I missed school, so I’m now behind and that’s making me worried. I also missed our soccer tournament, had to miss a few band practices and my friends and family are really worried. I really do not want to go through that again, but I just have so much on my mind right now that I sometimes forget to take my medications.

**Clinician:** On the one hand, you realize you have a busy schedule and that its easy for you to get preoccupied or forget to take your medications for your asthma yet on the other hand, when your asthma became worse it was terrifying and you missed out on many important things in your life. I wonder if you would want to explore ways to work together on balancing your busy schedule and your medications so you do not have to miss out on soccer, band and avoid needing to go to the hospital again?

**Patient:** Yeah, that would be good. If I could figure out a way to be able to balance all this stuff, it would make me feel calmer, in control and help me with soccer, band and just feel better.
Rapid Assessment of Risk for Physical Aggression: Is the BRACHA an Answer to Our Prayers for Safety?

Dr. Sorter, a co-investigator from Cincinnati Children's Hospital, provided essential clinical expertise in the BRACHA development, which started with 67 questions. Douglas Mossman, MD, co-investigator and professor of Psychiatry at the University of Cincinnati, provided outstanding statistical guidance on complicated analysis to our team, including several frustrated and exhausted statisticians. Over time, the long, tedious BRACHA went from 67 questions to 14 questions by determining which questions were most predictive. The current BRACHA includes two observational questions and 12 historical questions that should be administered in the Emergency Room prior to admission to the child and adolescent psychiatric unit. Since gathering information on new patients in the Emergency Room can be challenging, the BRACHA questions are quick, straight-forward, and can be easily answered while completing a standard psychiatric evaluation, even if prior and current medical records and diagnoses are not available.

The BRACHA was proven to be reliable and valid (Barzman et al. 2011; Barzman et al. 2012). We decided to focus on inpatient psychiatric units because it is a controlled environment where we could carefully evaluate the type, frequency and severity of aggression with the use of the Overt Aggression Scale (OAS). We started the BRACHA research in 2004 prior to the use of electronic health records (EHR) but over the past several years the use of EHR rapidly generated a large database of over 5,600 unique patients (ages 4 to 18 years) who were admitted to our child and adolescent psychiatric units. Although over 10 other sites have contacted me about using the BRACHA, only one site, in Regina, Canada, has been conducting original research with the BRACHA for their child and adolescent psychiatric unit. The next step at our site is to create a computer program that will assess different types of risks associated with aggression for each child after entering demographic data (e.g., age, sex, previous hospitalization, living situation) and the BRACHA score. In the future, we would like to collaborate with more sites to generate specific databases and computer programs for each region of the country and other countries. Our data from Cincinnati is not expected to be helpful for other sites around the nation or in other countries because of the differences in behaviors and cultures in different locations.

Among our findings, we identified that certain demographic characteristics were correlated with an increased risk for aggression. While race was not correlated with aggression in our research, we did find that a younger age, living in a foster home/group home, previous psychiatric hospitalization, and being male were all correlated with increased risk for aggression. Since younger children (seven years and younger) have an elevated baseline rate of aggression and are frequently aggressive and impulsive during hospitalization to a psychiatric unit, the BRACHA is not useful for this age range. Simply knowing that a patient is male and seven years old or younger at admission provides enough information to categorize the patient at high risk for aggression on the unit. We found that with age range 8-11 years, the BRACHA is more useful and is most useful for adolescents who range from 12-18 years.

The BRACHA has been clinically useful for our units for several reasons. First, we are able to quickly identify high-risk patients and develop a safety plan prior to their arrival to our unit. Second, psychiatrists and directors of the units can assess the acuity of the patient and unit by looking at the BRACHA scores during rounds. For patients with high BRACHA scores, the psychiatrist can prioritize medication changes and PRN (pro re nata: when necessary) orders to improve the safety of the unit. Having access to the Overt Aggression Scale (OAS) scores
on each shift is helpful for the staff and clinicians in understanding the previous 24 hours prior to seeing the patient. The OAS (which is used to measure frequency, type, and severity of aggression) is a completely different scale than the BRACHA (which is a predictive scale).

We are also using the BRACHA as one of two scales in our school violence research (Barzman et al. 2016). Our goal is to create a cell phone app to assist interviewers with assessing risk for school violence in real-time. We have completed this protocol on 35 subjects so far and our first goal is 100 subjects.

In conclusion, the BRACHA has been easy to use and clinically useful at our hospital. In order for the BRACHA to be clinically useful for other sites, collaboration and further research is needed in different regions of the country. Since the analysis is complicated and time consuming, funding is needed to further develop this research, build databases, continue research in the area of school violence, and create computer programs for sites around the country.

References


Dr. Barzman is an associate professor of Psychiatry and Pediatrics and director of the Child and Adolescent Forensic Psychiatry Service at Cincinnati Children’s Hospital Medical Center. He can be reached at Drew.Barzman@cchmc.org.
The life experiences of International Medical Graduates (IMGs), their ability to meet various challenges and their diverse cultural and linguistic background make them a crucial group of psychiatrists who will likely help meet the future demand for child and adolescent psychiatrists (CAPs). The IMG Caucus was started at the 2012 AACAP Annual Meeting. The Diversity and Culture Committee led the annual caucus aimed at addressing the needs of the IMG-CAPs.

The IMG Caucus is an informal group designed to provide an official forum for IMG-CAPs and trainees to address various issues. This includes professional development and support in a collegial and a nurturing environment. Some of the topics addressed include faculty and peer mentoring, career pathways, and IMG-focused AACAP training and educational initiatives. Challenges and opportunities to provide psychotherapy, as well as navigating a dual-learning curve as immigrants and residents, were discussed. Helping IMGs develop a unique position as potential leaders in global mental health was addressed. The IMG caucus also provided opportunities to advocate for IMG-related issues through the AACAP and other groups including the American Psychiatric Association. The IMGs were able to meet other colleagues from various parts of the country who validated their experience and provided them with helpful suggestions. Non-IMG child and adolescent psychiatrists were invited to join the caucus and participate in the discussion, in the hope that their presence would provide an opportunity for the IMGs to share ideas and exchange experiences.

I had the privilege of co-chairing the IMG caucus for the past four years. Members of the AACAP leadership attended the annual caucus and provided valuable input to the attendees and the co-chairs. The number of the IMG attendees and their issues varied from year to year. Some of the issues addressed during the caucus included: language barriers and accent issues, career development, training and education, observership, and being active within the academy, as well as how to help the next IMG group.

A brief survey, which addressed seven areas, was completed by most of the attendees. These areas included: most challenging barriers, connecting to a mentor, having a current mentor, helpful tools for progression in careers, discrimination, desirable personal characteristics, and how AACAP can better assist IMGs.

The two main areas identified by the IMGs in response to the survey included visa issues and mentorship. To address the visa issues, Elizabeth Reed, a licensed lawyer from San Antonio, Texas, addressed the IMGs visa concerns in 2015. Martine Solages, MD, the co-chair of the AACAP Early Career Psychiatry committee, answered questions regarding the mentorship program during the 2016 Annual Meeting.

Some of the recommendations discussed during the 2016 caucus included providing opportunities for face-to-face interactions, in collaboration with the Early Career Psychiatry Committee, between the IMG-CAP mentees and prospective mentors for the upcoming 2017 AACAP Annual Meeting in Washington, DC. Another recommendation was to increase the interaction with the IMG-CAPs who returned home after advanced training, or the IMGs attending the AACAP Annual Meeting from their home countries, in order to upgrade psychiatric care in their respective countries, by collaborating with the AACAP International Relations Committee. A final recommendation was for the seasoned IMG-CAPs to dialogue with the AACAP leadership regarding offering their expertise to support the new generation of IMG-CAPs.

Over the years, IMGs have contributed greatly to the fields of psychiatry and child psychiatry. It is hoped with future opportunities to receive training, mentorship and support, they will continue to provide the field of child and adolescent psychiatry, their patients, and families with outstanding contributions. As child and adolescent psychiatry continues to be a shortage specialty, IMG-CAPs with their diverse culture and linguistic and religious backgrounds, will help address the needs of America’s growing diverse population.

Dr. Adam is a child and adolescent psychiatrist and clinical associate professor of Psychiatry at the University of Missouri-Columbia. She may be reached at adamb@health.missouri.edu.
79% of children ages 6-17 with mental illnesses do not receive treatment

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

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

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.

American Academy of Child & Adolescent Psychiatry
Wwww.AACAP.org
I love playing as a demon hunter!” the brazen 12-year-old pro-
claimed as he dashed around his psychiatric’s office. “I also love using
the crusader as well because he can use shields and deal heavy damage.” His
exasperated mother sighs. “I’m sorry. He just gets so excited after he plays these
video games. Half the time, I have no idea what he is talking about. But the
real challenge is getting him to stop,” she states as her son continues to dance
around the mahogany furniture, battling imaginary beasts that lay before him.

The video game industry has been
growing vigorously since its inception
in the 1970s. From the advent of the
arcade game Pong to the recent release
of the virtual reality headset Oculus Rift,
video games have continuously evolved
and grown in popularity. From 2000
to 2015, the video games sales in the
United States tripled to 16.5 billion dol-
las annually (ESA, 2016). The number
of video game players has ballooned
to 155 million Americans. Of these, 42
million are children and adolescents
(ESA, 2016). While youth are spend-
ing more and more time playing video
games, parents and providers alike often
struggle to understand the arcane world
of video games. However, understand-
ing the genre of video game offers an
opportunity for child and adolescent
psychiatrists to build rapport with our
patients, gain insight regarding their
inner world including motivation for
playing, and use video games as a strate-
gic tool in patient care.

The first genre is the first-person shooter
(FPS). Here, the video game player
takes control of a virtual character and
perceives the virtual world through the
avatar’s eyes and typically interacting
with the world by the point of a gun.
Each player tends to have access to a
diverse set of weapons, and has the
option to either play through a story in
an offline version or play online com-
petitively with other players. First-person
shooters tend to be action-packed, relying
heavily on the player’s reaction time and
understanding of the virtual environment
as well as their own and their opponents’
weapons and abilities. When players
eliminate enemies (whether controlled
by computer A.I. or other players), they
gain experience points and wealth. This
virtual currency allows players to upgrade
weapons, unlock new game content, and
achieve a higher rank or status, which
demonstrates the player’s skill level to
other players. Each first-person shooter
features violence, to a varying degree.
For example, Call of Duty and Battlefield
are two games in which a player takes on
the role of a fictional soldier in a fictional
or real-world wartime setting. These
games are rated “Mature,” or appropriate
only for players aged 17 or older, by the
Entertainment Software Rating Board
due to the amount of violence, blood-
shed, gore, and strong language the
players engage in and witness (ESRB,
2016). However, other games such as
Overwatch, tone down the violence with
cartoonish animations, fantasy storylines
that distance players from realistic sce-
narios, and display less blood and gore
in comparison to their “mature” counter-
parts. They are rated T, or appropriate for
players aged 13 and older.

Real-time strategy (RTS) video games are
an increasingly popular genre with young
players. Instead of a first-person layout,
players take a third-person perspec-
tive, looking at an arena in which they
participate as a leader who allocates
resources to build defensive and offensive
units and defeat the opposition via defeat-
ing enemy troops or destroying their
resources. These games focus on strategy
and matches tend to last significantly lon-
ger than the first-person shooter contests.
An example of a game of this sub-type
is League of Legends, a fantasy-based
game where players assume the role of
a “champion,” battling with swords and
sorcery in an online arena against other
players or an offline arena against com-
puter-based AI. Similar to the first-person
shooter, each player is awarded experi-
ence points for killing opposing enemies
or destroying their enemy’s base (known
as the “nexus”). Experience points allow
players to increase their character’s skill
set as well as demonstrate their skill and

Ashvin Sood and Paul Weigle, MD
rank to other players. *League of Legends* is currently the most popular personal computer game in the world, with data indicating 1.3 billion hours of playtime each month as of 2012 (Gaudiosi, 2012). *League of Legends* received a T rating from the ESRB due to fantasy violence. Players are extremely competitive, and the 2016 League of Legends World Series finals was viewed by 20,000 fans live and 43 million viewers online, rivaling the Major League Baseball world series final.

The third genre that has a strong following in the video game community is the massive multiplayer online role-playing games (MMORPG). The most well-known example is *World of Warcraft*. Set in a fantasy world, players create an avatar based on their preference of fighting style, fantasy race, appearance, and gender. The character interacts with other players online to complete quests, defeat monsters, and find treasures. Victories in the battlefield are rewarded with experience points and in-game currency that can be used to acquire new skills, abilities, and gear (Rignall, 2015). However, MMORPGs have a greater social element during play in comparison to other genres of video games. Players interact with each other via selling or trading weapons and armor, owning in-game real estate, protect and heal one another, affiliating in competitive guilds, and creating virtual romantic relationships. *World of Warcraft* has earned a T rating due to overlying adult themes such as characters having the ability to consume alcohol, killing enemies with medieval weapons and magical effects, and sexually suggestive themes including provocative dress.

While these three genres of video games attract children and adolescents in high quantities, there are a number of other popular genres including sports and racing simulation games, fighting games, survival horror games, and third person sandbox games. The world of video games is constantly evolving, requiring mental health care providers to read about, watch videos of, or even play the games our patients are playing in order to keep informed. Furthermore, having an understanding of the games children play means that providers can integrate video game culture into our patient’s care. From advising parents on the appropriateness of game content to establishing fair boundaries with the child regarding healthy play habits using video terminology, a working knowledge of video games provides opportunities to prevent children and adolescents from engaging in unhealthy, traumatizing or even addictive video game play. Hence, it is our turn to pick up the controller and join the game.

**References**


Ashvin Sood is a 4th year medical student at the Virginia Commonwealth University School of Medicine and is planning to pursue a career in child and adolescent psychiatry. His interests include ADHD and the impact of social media on the adolescent brain. He can be reached at Sooda2@vcu.edu.

Paul Weigle, MD, is a child psychiatrist and associate medical director at Natchaug Hospital in Connecticut, where he cares for youth at the Joshua Center Partial Hospital Programs. Dr. Weigle is a co-chair of the American Academy of Child and Adolescent Psychiatry’s Media Committee, having served on the committee since 2002. He studies the effects of video game and internet habits on the mental health of youth, and has authored numerous articles on the topic. He can be reached at paul.weigle@hhchealth.org.
CONSUMER ISSUES COMMITTEE AND MEDIA COMMITTEE

Geek Minded Psychiatry: Introduction to Cosplay and Fanfiction

Dale Peeples, MD, and Jennifer Yen, MD

In the past few decades, geek culture has garnered increasing attention from mainstream media and the general public. Discussions about comic book characters are no longer relegated to the back room of a second hand bookstore where adolescent males discuss who would win the hypothetical battle of Superman versus Spider Man (the answer: it depends on whether Spider Man was supercharged with a red sun laser). “Geek” entertainment dominates the box office with comic book adaptations earning billions of dollars and fan conventions or “cons” drawing crowds of over 100,000.

Despite being considered pejorative historically, the term geek has been reclaimed and reinterpreted by the targeted community. Groups of enthusiasts get together to discuss their favorite entertainment and engage with one another in creative ways. Comic books, science fiction, and animation fuel geek culture. Conventions, costuming, fan fiction, and gaming are some of the social and creative outlets that bring the community together. There are countless facets of geek culture, including LARPing, filk music, bronies, furries, anime, manga, cosplay and slash fic. As an introduction, we focus on two creative aspects—cosplay and fanfiction.

Cosplay

Cosplay, a portmanteau of “costume” and “play,” has its historical roots in the American science fiction conventions of the 1930s. More recently, it developed in Japan in the 1980s and 1990s and spread to the rest of the world. Donning the costume is only half of the equation. The “play” element refers to playing a role of the character, not just copying the appearance. It can be subtle, affecting the mannerisms associated with a character as one poses for photographs. There is often a strong “work” element as well. Costumes can involve hours of labor.

Although cosplay can provide a positive creative and social outlet, parents sometimes have concerns. Through a better understanding of cosplay, psychiatrists can help families discuss these differences of opinion, while helping adolescents maximize the benefits and minimize the risks. We have worked with families that viewed cosplay as a waste of time and money. This argument can be leveled against almost any leisure activity so it is worthwhile to explore how the parent views cosplay as different from other hobbies. Are they concerned their child is getting too fanatical about cosplay? Is it taking their child away from other activities? Although it is possible to spend thousands of dollars on costumes, you can see excellent work using the most basic items, such as paint and cardboard, so cost should not be prohibitive.

Adolescents are at a stage where they are expected to explore identity, so moving from old to new interests is expected. Overall, cosplay is as safe a sandbox as any for an adolescent to play with looks and appearance. Families may also have concerns related to gender expression. “Crossplay” or cross dressing occurs with some regularity in cosplay communities, so much so that it is generally not even commented on at conventions. It is worth discussing with an adolescent his/her decision to play a certain character of the opposite sex, but it would be a mistake to think that this is necessarily due to some underlying gender dysphoria.

Fanfiction

Fanfiction, or “fanfic,” is created by fans of a specific book, television show, or movie. Part of the appeal stems from an individual’s ability to delve into the backgrounds, outside lives, and potential futures of their favorite characters through writing. It offers a chance for regular people to participate in molding and directing the journey of the characters.

What started out as an expressive outlet for fans has turned into a vast network of people who create and consume such works. Like-minded fans are able to find stories by authors of varying degrees of talent. In some cases, collaborations have occurred either within the same story arc or as chains in a linked anthology. A plethora of different themes, topics, and pairings can be found; and, in some cases, brand new characters can be brought to life. Varieties of fanfiction are typically gathered on websites and servers dedicated to their collection and cataloguing such as Fanfiction.net, AOK3 (Archive of Our Own), A Teaspoon and An Open Mind, Quotev, Kindle World, and Wattpad.

One of the reasons fanfiction has grown in popularity is that it is unrestrictive in nature. Authors of all ages (although typically restricted to 13 or over) are able to post and share their work. The websites offer the ability to let the writer know that the work has been lauded, and readers can leave comments on the story, which can be responded to. With a diverse audience, the authors can
As a less intimidating way to engage therapists, many have suggested that fanfiction offers writers and readers a way to fulfill a variety of practical and emotional needs. Many writers indicate that they often use the pre-existing material of their fandom as a platform until they are skilled enough to create original works. Others have disclosed that they utilize the characters as a vehicle to work through their own issues or challenges. This has led some therapists to use fanfiction as a form of expressive therapy. Intended as a less intimidating way to engage patients and encourage exploration of sensitive topics, the written works can reveal a great deal about the inner workings of the individual while giving the clinician a way of providing therapeutic interventions.

**Clinical Considerations**

As geek culture grows in popularity, more children and adolescents are drawn to it and self-identify as geeks. It is not adequate to merely state that one is a geek, as many subsets are present under gaming, anime, comics, science fiction, and fantasy, to name a few, each with their own quirks and characteristics. Within the groups, one can find acceptance, support, and understanding – factors crucial to the healthy development of self-esteem and identity. Similar to sports, drama, music, and dance, it serves as a creative outlet and coping mechanism for many patients seen in clinical practice.

Just as clinicians use other activities to develop rapport and explore the inner workings of patients, geek culture can be an innovative tool to develop insight and administer therapeutic interventions. Techniques like superhero therapy and cinematherapy are being explored as adaptations of traditional methods. Although more time is needed to determine the efficacy of these modalities, it offers a tantalizing new approach for demystifying mental healthcare and improving patient engagement and participation in treatment.

---

**Note:** We thank the AACAP Consumer Issues and Media Committees for their support and contribution to this article.

---

Dr. Peeples is an associate professor of Child and Adolescent Psychiatry at the Medical College of Georgia and the assistant training director in the Child Psychiatry division. He serves on the AACAP Media Committee, and has a particular interest in geek culture and has presented on such topics at the past two AACAP annual meetings. He may be reached at dpeeples@augusta.edu.

Dr. Yen is in private practice in Houston, Texas. She is an assistant clinical professor of Psychiatry and Behavioral Sciences at Baylor College of Medicine. As a member of the Consumer Issues Committee, she has a passion for sharing knowledge about geek culture and diversity. She may be reached via email at jlyenmd@gmail.com.

---

**JAACAP Connect**

JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry promoting the development of translational skills and publication as education. The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences. We work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles.

[www.jaacap.com/content/connect](http://www.jaacap.com/content/connect)  
connect@jaacap.org
Dr. Kramer makes a compelling case for integrating child psychiatry and pediatric practice. This model of care is beginning to have application for adult services, with the integration of behavioral health and primary care (Bland, 2014). The American Psychiatric Association provides training in this model under a federal grant (Moran, 2015).

The danger in this sort of integrated model is that it can lead to elimination of adult psychiatry training as a prerequisite, replacing it instead with pediatric medicine.

In the event that this sort of discussion begins in our Academy, I would like to make the case that Adult Psychiatry should remain a prerequisite for Child Psychiatry specialization.

Adult Psychiatric Training impacts the way trainees understand mental illness, deal with children, and work with parents in the following ways.

- It teaches how to manage severely ill parents, or relatives, for the child and family’s benefit.

- It follows the course of childhood psychiatric and medical illnesses allowing trainees to see the adult outcomes, improve care for parents, and institute prevention strategies for children.

- It avoids the specialization attitude that “I do not treat this, so I do not have to know about this, so it is someone else’s job.” With the current emphasis of integrating behavioral medicine into family practice, it would be preferable to have **one** psychiatric consultation with an adult and child and adolescent psychiatrist, instead of **two**, one with an adult psychiatrist and the other with a child and adolescent psychiatrist.

- It encourages reading inclusively in psychiatry, so the unity of the discipline is maintained and insights from the adult literature can be incorporated in the treatment of children and families.

- It offers the opportunity to get training in adult internal medicine to understand and possibly manage medical problems that arise with parents.

- It prevents patients from aging out of care just because they are no longer children or adolescents, and so protects continuity of care and established doctor-patient relationships.

The dean of students at the medical school I attended, Joe Gardella, used to harp on the idea, “The more medicine you know, whatever you specialize in, the better physician you will be.” I spent two years after an internal medicine internship as a family physician in the Zuni Indian Reservation in Zuni, New Mexico, delivering babies, and treating them as well as the adult and geriatric population. He was right. It is an invaluable support for understanding adult and child psychiatry.

Maybe we need two routes for training in child psychiatry: one through pediatrics and the other through adult psychiatry?

Whatever happens, “Let us not throw out the baby with the bath water” by eliminating the role of adult psychiatry in child psychiatry specialization.

References


Kim J. Masters, MD
AACAP’s Legislative Conference and Assembly Meeting

May 11-13, 2017

AACAP’s 2017 Legislative Conference and Assembly Meeting will take place in Washington, DC, from May 11-13, 2017. Join us for both events to advocate for children’s mental health.

**AACAP Legislative Conference**

On May 11 and 12, AACAP’s Government Affairs team will teach you about the legislative process, provide you with advocacy materials to help you develop and deliver the most impactful messages, and schedule your meetings with legislators on Capitol Hill. Join us as we advocate for children’s mental health, and make your voice heard!

Visit [www.aacap.org/LegislativeConference](http://www.aacap.org/LegislativeConference) for more information or contact Zachary Kahan, Advocacy & PAC Manager, at zkahan@aacap.org or 202.587.9669.

**AACAP Assembly Meeting**

On May 13, AACAP's Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.

Visit [www.aacap.org/Assembly](http://www.aacap.org/Assembly) for more information or contact Megan Levy, Executive Office Manager, at mlevy@aacap.org or 202.966.1994.
Honor Your Mentor

Each year in the March/April issue of AACAP News, we take the time to honor our mentors and say thank you to those who have made a significant difference in our professional and personal lives.

**Michael Bloch, MD, MS**

I had the opportunity to meet Michael four years ago when I was a medical student, through my involvement with the Klingenstein Third Generation Foundation funded by the American Academy of Child and Adolescent Psychiatry. The “Games” as they are fondly known as were held at Harvard medical school that year in 2013. Soon after, I arranged a research externship during my fourth year of medical school to work in Dr. Bloch’s lab at the Child Study Center, and we ended up working on several projects together. That experience was one of the most transformative experiences of my academic career this far. Working with Michael was truly a pleasure. His brilliance, compassion, humor, and humility are inspirational. He continues to mentor me which has been significantly meaningful in my personal and professional development. He is also an outstanding clinician. He has helped me appreciate the tremendous value that the mentorship can provide not only at a personal level, but in promoting passion, creativity, collaboration. I am a changed person for the better because of him.

~ Anjali L. Varigonda, MD

**T. Berry Brazelton, MD**

T. Berry Brazelton, MD, 2007 AACAP Catcher in the Rye Humanitarian Award recipient, has mentored generations of pediatric health and mental health clinicians, researchers, and leaders around the world. Many contributed to Nurturing Children and Families, Building on the Legacy of T. Berry Brazelton (Eds. Lester and Sparrow, Wiley, 2010). Since 1996, the Brazelton Touchpoints Center at Boston Children’s Hospital (www.brazeltontouchpoints.org) has disseminated the key elements of Brazelton’s mentorship to family-facing professionals and organizations everywhere. I am deeply grateful for his many years of mentoring, and for the honor of serving as director of the Center that he founded.

~ Joshua Sparrow, MD

**Patricia Butler, MD**

I’d like to honor Patricia Butler, MD, who was an inspiration to me during my days at UT Houston Medical School. I had 2 children ages 8 and 10 when I started and I definitely needed her guidance and wisdom as a mom and later as a prospective psych resident. I did end up being a Child Psychiatrist after all. Thanks, Dr. Butler, for your wisdom, patience, and inspiration.

~ Terrie A. Mailhot, MD

**Brady Case, MD**

For Dr. Brady Case who taught me that you can be warm, funny, compassionate, zany, creative, and irreverent, and that more than anything you can love your patients, and they will follow you down the rabbit hole of treatment and come out better. He brought me into the world of OCD and exposure and showed me how to take care of families and not just individual patients. He taught me to be kind to myself and ask for more from the world. As a female physician, a clinician, a mother-many thanks for changing my life.

~ Amy Funkenstein, MD
Norbert Enzer, MD

I would like to honor Norb Enzer, MD, as a mentor. I had just completed my residency and started as Chief of the Child Psychiatry Service at Massachusetts General Hospital. It was easy to be chief as I was the only full time staff member. My Chair, Tom Hackett, MD, suggested I contact his friend Norb as I went to my first AACAP meeting in 1979. Norb was generous with his time and advice. He taught me about the Academy, leadership issues in my new role, and expressed confidence in my abilities. Although almost 40 years have passed, I often remember his warmth, support, and sensitivity at a very meaningful time in my life as a child psychiatrist.

~ Michael Jellinek, MD

Jean Frazier, MD

I am grateful to Jean Frazier, MD, whom I’ve known since medical school. She has been supportive of my work-life balance needs, which was not exactly the same pathway that she travelled. For example, my husband took a job in upstate NY to invest in his own career goals, which meant that I needed to accept a job without academic affiliation. Dr. Frazier offered me an adjunct appointment at Harvard in order to continue to teach, finish up my research project, and, more importantly, to continue lifelong learning and mentorship. When I was able to return to academics, Dr. Frazier continued to rally for me even when I was in doubt about my leadership skills and potential. Now in my role coaching both trainees and faculty at UMASS, I continue to strive to emulate Dr. Frazier by mentoring people to open their eyes to the different pathways possible for professional success.

~ Mary Ahn, MD

Anne Glowinski, MD, MPE

Dr. Glowinski (Anne) lovingly refers to her current and former trainees as her “ducklings.” I have had the honor to be one of Anne’s ducklings for the past 11 years, first as a general psychiatry resident, then child fellow, and now as a remote mentee. Anne is a triple threat – excellent clinician, educator, and scientist. She is clinically brilliant, and has a way of making her patients and their families feel understood. She is innovative, constantly bringing creative ideas to training. She encouraged my passion for teaching, and challenged me to study educational outcomes. While I was a fellow without formal research training, Anne helped me secure private grants to build and study specialized workshops for pediatricians. She patiently helped me to write my first paper, and dramatically explained how to capture the reader’s attention in the introduction, “You paint the landscape of a critical, understudied problem, and then ride in on your white horse to solve the problem.” I appreciate her example, and have followed in her footsteps as a future training director for our child and adolescent psychiatry fellowship program in Florida. I am proud to help inspire and encourage the next generation of child psychiatrists, as Anne has done for me.

~ Elise Fallucco, MD

James Hudziak, MD

I met Dr. Hudziak more than a decade ago, as a freshman in college. His lecture on child psychopathology inspired me to pursue medicine and child and adolescent psychiatry. I was fortunate to attend medical school at UVM, where I became involved in Dr. Hudziak’s research and collaborated on a poster presented at AACAP 2015. I was honored to have him hood me at my recent graduation and thrilled to introduce him as a speaker at the 2016 Medical Student and Resident Breakfast. He has influenced me to work hard, think big, and not take things too seriously.

~ Cordelia Y. Ross, MD
Michael Kase, MD

When I first interviewed with Dr. Michael Kase for UCLA-Kern Child and Adolescent Psychiatry Fellowship, I could sense his strong enthusiasm and passion for child psychiatry. He was very encouraging about different learning opportunities in training and about the field’s growth. Since the beginning, Dr. Kase has been a wonderful teacher, always approachable and readily available, in answering questions, teaching interesting and detailed concepts, and giving extremely useful advice about preparing for exams, career development, and clinical patient care. His mentorship has been pivotal for me as a new graduate working in psychiatric emergency setting with children, adolescents, and adults.

~ Sadia Abdul Ghaffar, DO

Elizabeth Lowenhaupt, MD

Dr. Elizabeth Lowenhaupt is a mentor to myself and so many medical students, residents, and fellows. She does broad and inspiring work with incarcerated youth, as a professor, and as an agent of systemic change. Dr. Lowenhaupt introduced me to all things AACAP and helped me attend my first national meeting. Her mentorship is that warm feeling when someone you look up to remembers a detail about you. It’s that feeling that someone in the field of your dreams feels you belong there. She’s spreading the gospel of Child and Adolescent Psychiatry in dozens of nurturing interactions every day.

~ Alan Atkins, MD

Dr. Jesus-Martin Maldonado-Duran

Dr. Martin Maldonado was my mentor at the Menninger Clinic. He introduced me to the world of Infant Mental Health, supported my interest in Early intervention and prevention. He took me on home visits, took WIC clinics and the NICU. I will be forever grateful for his impact on me and the way I think.

~ Stephen R. Mandler, DO

Joseph Malloy, MD

I would like to honor my mentor, Dr. Joseph Malloy, for exposing me to so much it is hard to put it into words. What started out as a professional mentor, evolved into a father figure and someone who has added so much to my and my son’s life. Professionally and personally he has a way of teaching and correcting me without ever making me feel inferior or bad.

I am forever grateful for his genuine care for me. He truly inspires me and wants the very best for me, like a father would. We may not be related by blood, but he is family to me. I appreciate what a blessing he has been, and I do not think I will ever be able to express that. I do hope one day that I can be to someone, what he’s been to me.

~ Lora M. Clack, MD
John March, MD, MPH

John March, MD, MPH, has impacted my professional life in immeasurable ways, and continues to do so after two decades. Without question, I would not have my current research career without John. It began with my decision to train at Duke, later his long-distance role as my K-23 mentor, more recently my decision to transition to research administration, and a multitude of things in between. John has consistently provided me with tremendous mentorship and sage advice, all the while serving as a spectacular role model for what it means to be a world class academician and a compassionate human being.

~ Christopher J. Kratochvil, MD

Andrés Martin, MD, MPH

As accomplished as he is disarmingly kind, Andrés Martin drew us into his family of children's mental health providers through his tireless work as a clinician, teacher, researcher, and administrator. We want to thank him for everything he has done for us: from inviting us into his home to work on research projects, to supporting us through our first child inpatient unit rotations, to guiding us through the stages of our profession. We will carry with us throughout our careers his love of and dedication to children's mental health. Gracias por todo, profesor!

~ Jack Turban, MD and Billy Lockhart, MD

Yiu Kee Warren Ng, MD

Seven years ago, I was lucky enough to have Dr. Warren Yiu-Kee Ng be assigned as my clinical supervisor at NYP-Columbia when I was a CAP fellow. Our supervision sessions tended to go beyond the boundaries of talking about my patient load, as topics about career goals, our shared cultural backgrounds, and trends in psychiatry were brought up. After fellowship, I continued to reach out to Warren for guidance, especially when I was embarking on career transitions. Today, I remain grateful to have his insight, support, and mentorship and am proud to be a board member with him on the New York Council on Child and Adolescent Psychiatry.

~ Annie S. Li, MD

Josie Olympia, MD

There is presence of hope, adventure, and courage in reflecting on your impact. You have a reputation of encouraging excellence with an emphasis on genuine patient care as the crux of being an excellent physician. For the past 15 years, you have voluntarily provided service to our community via your monthly Family Psychoeducation group. It has been two amazing years as your mentee.

~ Isuan Suzy Asikhia, MD
HONOR YOUR MENTOR

Jon Shaw, MD

Jon Shaw is Chief of CAAP at the University of Miami where he has been our division’s hardest worker for decades. As a resident, I frequently lunched with him to discuss psychotherapy cases and attended his lectures for psychiatry and psychoanalytic trainees. His encyclopedic knowledge, complex case formulations, and therapeutic eclecticism were awe-inspiring. He constantly inspired trainees to seek ever deeper understanding of patients. My awareness of what was possible in psychiatry grew profoundly and CAAP training became essential. Now in my second year of fellowship, he still surprises me with his genius, insatiable curiosity, generosity, dedication, and superhuman productivity.

~ Nils Westfall, MD

Sabina Singh, MD

A bright woman, with clever ideas, and expertise. It sounded intimidating to be supervised by someone like her. But during our very first supervision sessions, this brilliant woman showed me how much she appreciated my approaches and understood my shortcomings. She is always dedicated to our/her patients’ wellbeing and mine too. She has been teaching me psychopharmacology, psychotherapy, and also how to learn to accept “the system’s” and my limitations when dealing with the mentally ill. I was randomly assigned to have a child psychiatrist as my supervisor and could not be having a better role model of dedication, honesty, enthusiasm, generosity, compassion, and diligence.

~ Leah R. Steinberg, MD

Eric Spiegel, MD

He is a great mentor who fellows, residents, medical students, other Attendings (from both psychiatry and other fields) go to for advice and learning. He is someone that I strive to emulate.

The amount of compassion and empathy he shows to patients is inspiring.

~ Joshua Wilson, MD

Margaret Stuber, MD

Dr. Margaret Stuber at the David Geffen School of Medicine at UCLA, served as my mentor for the AACAP Summer Medical Student Fellowship and has significantly impacted my understanding and appreciation of the psychiatric field. From the first e-mail to present day, Dr. Stuber has been welcoming and encouraging throughout my medical school career. She consistently advocates for my personal growth by supporting me on my summer project, creating new connections with experts in the field, and offering new opportunities. I am so grateful for Dr. Stuber and am honored to be one of her mentees.

~ Catherine Chan
Fred R. Volkmar, MD, and Wendy K. Silverman, PhD

Fred and Wendy – I’ll never forget these two names. I owe to these incredible mentors full credit for my development as a scholar in Child and Adolescent Psychiatry. They have been unfailingly patient in helping develop my skills, provided me with worlds of opportunities, and supplied an abundance of personal support and guidance. I value their mentorship as one of the richest experiences of my career, and hold great affection for them both.

~ Gerrit van Schalkwyk, MD

Henry Work, MD

Hi. I’m back from 10 years in Paris where I’ve become a sculptor, and Henry Work is by far the person who sculpted me most as a Child Psychiatrist. Though Henry could be a bit crusty and minced no words, he knew what made children and teenagers tick and how organizations functioned. He had a knack for creating a unique and challenging learning environment. One might think Henry was quite conservative. When you got to know him, he was quite personable and liberal. In those days, the APA was an old boys club, with only one person nominated for President, each senior person getting their turn. Our group, called the Committee for Concerned Psychiatrists, undertook to “green” the APA electoral process by requiring that for each position there had to be at least two candidates. Behind the scenes, Henry was a powerful source of inspiration and support, and a diplomat soothing the old guard.

It is a pleasure to recommend his as my mentor.

~ Kent Ravenscroft, MD

Life Members Reach 170!

No, not 170 years old. But, 170 lives you have impacted.

Impact.

Since 2010, the Life Members Fund has made an investment in 92 residents and 78 medical students. This includes 17 residents and 13 students in 2016! If you attended the Life Members dinner in NYC, you got to meet these young superstar future Owls!

Donate.

Your donations have made this achievement possible. We are in the midst of a mental health crisis, which comes at a time when our skills have never been more important. Yet, the deficit of available child and adolescent psychiatrists is widening. Life Members are closing this gap. Let’s keep it up.

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

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

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

2017 Owl Pin. Remember, if you donate $450 or more to the Life Members Fund between November 1, 2016 and October 31, 2017, you will receive a limited edition 64th Anniversary OWL PIN for the 2017 Annual Meeting in Washington, DC.
Your Evaluations Matter! How AACAP Handles Member Reports of Bias

Eric Williams, MD, and R. Andrew Harper, MD
Co-Chairs, Continuing Medical Education Committee

These are words that every AACAP meeting attendee should see on evaluation forms and hear from presenters. For the past 10 years, Annual Meeting attendees have ranked the conference as “free of commercial bias” with the highest rating compared to any other elements being evaluated. (AACAP’s Management of Relationships with the Pharmaceutical Industry, 2013, http://www.aacap.org/AACAP/About_AACAP/Transparency/AACAP_Management_of_Relationships_with_the_Pharma_Industry.aspx) This is great news regarding the commercial-free content of presentations, but what happens if an attendee selects “no” on the evaluation form, or the speaker does not present a disclosure slide?

One of the charges of AACAP’s Continuing Medical Education (CME) Committee is “to address the potential conflicts of interests and resolve issues that arise.” Over the years, the CME committee has refined that process.

Let’s say that Dr. Doe presents on the pharmacology of depression. He reveals no relevant conflicts on the required conflict-of-interest slide (which should almost always be the one after the slide title), then talks about how medication X has been especially helpful for depression. Dr. Doe is a well-known speaker, so he draws 500 people to his talk. Out of the audience, one or two attendees state on the evaluation form that Dr. Doe was biased toward the medication. If none of the other 498 report this on their forms (which could happen, because AACAP attendees are among the best when it comes to turning in evaluations), when the CME Subcommittee on Comment Review looks at the ratings, the review process would end there. However, if several attendees make similar comments, especially if the comments are detailed (“Dr. Doe stated that medication X could get results not borne out by research, and seemed to push medication X for almost every indication,” as opposed to “Dr. Doe seemed biased.”) then the committee members may listen to the recording of the presentation (if available) and/or review the slides. If necessary, a subcommittee member will then contact Dr. Doe and share the concerns. This approach allows Dr. Doe to give his input on the concern, and informs him of the types of issues being raised about his presentation. Usually, the follow-up ends there. In cases of particular concern, a presenter may be contacted by the Program Committee.

If there is a pattern to the comments, or a pattern to comments across presentations by the same presenter, that may be a consideration by the Program Committee for future submissions by that person. The goal of contacting presenters is never punitive, but is done to ensure that all presenters maintain AACAP’s high standard for scientific presentations.

What happens if Dr. Doe forgets to disclose (either verbally or with a disclosure slide (if using PowerPoint))? In addition to attendee feedback, the medical student and resident monitors in each session are charged with looking to see that each presenter follows AACAP disclosure guidelines. If a monitor reports that a presenter forgot to properly disclose, a CME subcommittee member will contact Dr. Doe and remind him to include the slide next time.

Sometimes an attendee will remark that a speaker was biased because the speaker disclosed industry or other extracurricular support and remuneration. It is important to remember that making such a disclosure does not necessarily mean that there is a conflict, but simply gives the audience information about the presenter’s affiliations that could possibly lead to a potential conflict.

In addition to individual trends, the CME and Program Committees analyze comments about presentations within a conference as well as comments across various conferences. This information is then used to guide potential speakers in the Call for Papers instructions, make modifications to evaluation forms to better collect data, and detect possible concerning trends before they become larger problems. Just like disclosures do not always mean a presenter is biased, a trend is not always necessarily concerning. For example, members have made fewer reports over the years about industry-related bias, but have reported more about speakers who are felt to be biased because they elaborate on and discuss their own research. The goal of the Annual Meeting and other AACAP-sponsored conferences is to not only showcase standard-of-care and best practices, but also to expose attendees to research and methods that are cutting-edge, which may mean that not enough time has passed for the methods and results to be replicated by other researchers and reported in peer-reviewed journals.

The process of reviewing attendee comments and concerns should always be, and is, a work in progress, because the goal is to improve the content delivered to the audience, and leave each attendee with the confidence that AACAP programs remain the best in the industry.
According to AACAP’s 63rd Annual Meeting evaluations, the highest rated sessions in each presentation category were:

**Clinical Case Conference 5:** Domestic Sex Trafficking of Minors on Interstate 95 and Other Cases of Child Exploitation From Rhode Island: In-Roads to Intervention
*Chair: George Vana IV, MD*

**Clinical Consultation Breakfast 6:** The Individual Psychotherapy of Adolescent Sexual Abuse Victims
*Chair: John D. O’Brien, MD*

**Clinical Perspectives 41:** My Family and Me and Posttraumatic Stress Disorder: Applications of Evidence-Based Models to the Treatment of Military and Civilian Families With Young Children
*Chairs: Sylvia Turner, MD, and Daniel S. Schechter, MD*

**Honors Presentations 8:** Cultural Considerations in School Mental Health: Lessons Learned from Diverse Settings
*Chair: Shashank V. Joshi, MD*

**Institute 4:** Lifelong Learning Institute: Module 13: Relevant Clinical Updates for Child and Adolescent Psychiatrists
*Chairs: Sandra B. Sexson, MD, and Andrew T. Russell, MD*

**Media Theatre 11:** Short Term 12: A Review of Dynamics in an Adolescent Group Home
*Chair: Suzanne Shimoyama, MD*

**Member Services Forum 1:** Career Pathways for Women in Psychiatry: Job Selection and Negotiation
*Chairs: Alice R. Mao, MD, and Svetlana Lupashko, DO*

**Special Interest Study Group 12:** Problem-Based Learning in Child and Adolescent Psychiatry
*Chair: Anthony P. Guerrero, MD*

**Symposium 6:** Inflammation in Child and Adolescent Mental Illnesses
*Chair: Shannon Delaney, MD, MA*

**Workshop 26:** CARING at Columbia Head Start: Promoting Resilience Through Creative Art and Play and a Prevention Model for At-Risk Preschool Children and Families
*Chairs: Clarice Kestenbaum, MD, and Ian A. Canino, MD*

Please note that these rankings are determined by average overall ratings on session evaluations.

*Congratulations to all the presenters!*

We would like to acknowledge the first ten sessions to sell-out at AACAP’s 63rd Annual Meeting. In chronological order based on sell-out date, they are:

**Clinical Consultation Breakfast 10:** Master Clinician: John T. Walkup, MD: Treatment of Anxiety Disorders in Busy Office Practice
*Chair: John T. Walkup, MD*

**Clinical Consultation Breakfast 5:** Master Clinician: Timothy E. Wilens, MD: ADHD 401: When First and Second Line Treatments Don’t Work
*Chair: Timothy E. Wilens, MD*

**Clinical Consultation Breakfast 4:** Master Clinician: L. Eugene Arnold, MD: Complementary and Alternative Treatments for Attention-Deficit/Hyperactivity
*Chair: L. Eugene Arnold, MD*

**Clinical Consultation Breakfast 9:** Master Clinician: David A. Brent, MD: Adolescent Suicidal Behavior, Non-suicidal Self-Harm, and Treatment-Resistant Depression
*Chair: David A. Brent, MD*

**Workshop 1:** An Intensive Parent-Training Intervention Model for Behavior Disorders in Children and Adolescents
*Chair: Michelle Kaplan, LCSW*

**Workshop 36:** The Buddha in Therapy: Integrating Mindfulness Into the Treatment of Children, Adolescents, and Their Families
*Chair: Jill Emanuele, PhD*

**Clinical Consultation Breakfast 3:** Master Clinician: Karen Dineen Wagner, MD, PhD
*Chair: Karen Dineen Wagner, MD, PhD*

**Workshop 17:** Learning Disorders: Implications for Psychiatric Diagnosis and Treatment
*Chair: Lee I. Ascherman, MD, MPH*

**Clinical Consultation Breakfast 11:** Master Clinician: Melissa P. DelBello, MD, MS: Diagnosing and Treating Bipolar Disorder in Youth in the Age of DSM-5
*Chair: Melissa P. DelBello, MD, MS*

**Workshop 06:** Starting a Private Practice
*Chair: Alexander S. Strauss, MD*

Thank you to all of the Annual Meeting speakers for your contributions to AACAP!
Did you miss this year’s Pediatric Psychopharmacology Update Institute or Douglas B. Hansen, MD, Annual Review Course? Are you looking to learn something new?

AACAP HAS JUST WHAT YOU NEED!

- Hear top-rated speakers on hot topics in the field
- Review best practices
- Find answers to issues in clinical practice
- Catch up on sessions you missed

Session recordings from this year’s meetings (now including PowerPoint slides) are available to purchase individually or as part of a full conference set.

Visit AACAP’s Learning on Demand at [http://aacap.sclivelearningcenter.com](http://aacap.sclivelearningcenter.com) for more information and to see free samples of content available.

No CME credit is available with session recordings. Session availability subject to speaker permission.

New Research Poster Call for Papers

AACAP’s 64th Annual Meeting takes place October 23-28, 2017, at the Washington Marriott Wardman Park and the Omni Shoreham Hotel in Washington, DC. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, administration, etc. AACAP encourages submissions on neurodevelopmental interventions (helping children grow healthy brains), translational research, maximizing the effectiveness of community and educational child and adolescent psychiatry consultation, services research, and violence prevention.

Verbal presentation submissions were due February 15, 2017, and may no longer be submitted. Abstract proposals for (late) New Research Posters must be received by Thursday, June 15, 2017, and the online submission site will open in early April. All Call for Papers applications must be submitted online at [www.aacap.org](http://www.aacap.org). If you have questions or would like assistance with your submission, please contact AACAP’s Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
Yoga & Mindfulness Practices for Children – Card Deck

Jennifer Cohen Harper, Illustrations by Karen Gilmour
PESI Publishing & Media
Card Deck - $19.99

Yoga & Mindfulness Practices for Children is a fun resource to teach children the basics of yoga and mindfulness. The deck includes an introduction, outline, and over 50 colorful cards that teach activities through text and illustrations. The exercises are color coded and divided into five key elements: connect, breath, move, focus, and relax. Activities and practices include heart and belly breathing, feeling my strength, grounding in the present, managing anxiety, relaxing and restoring, engaging my compassion, checking in with my feelings, and naming my thoughts. Once each individual card is mastered, the user is encouraged to create a sequence of practices, using one card from each of the five elements. Additional content is also available online. These cards are an affordable and exciting way for parents and practitioners to introduce children to the healthy practices of yoga and mindfulness.

Becoming Mindful: Integrating Mindfulness Into Your Psychiatric Practice

Edited by Erin Zerbo, Alan Schlechter, Seema Desai, and Petros Levounis
American Psychiatric Association Publishing 2017
Paperback: 195 pages - $55.00

Becoming Mindful: Integrating Mindfulness into Your Psychiatric Practice is a practical guide for providers who wish to introduce mindfulness into their clinical practice and personal life. The book is organized into 11 chapters with key points and references at the end of each section. The first few chapters introduce mindfulness and explore the history and neuroscience of the practice. Subsequent chapters explore how to apply mindfulness in clinical practice, with examples of how to practice, teach, and manage common obstacles. Throughout the book are sample scripts and guided exercises to be used individually and/or with patients. The use of mindfulness in special patient populations is explored, including mood disorders, post-traumatic stress disorder (PTSD), substance use disorders (SUD), and attention-deficit hyperactivity disorder (ADHD). One chapter is dedicated to the use of mindfulness in child and adolescent psychiatry. Two appendices include audio-guided meditations and a list of helpful resources (e.g., books, articles, audio, web sites, and videos). Building on the increasing popularity of mindfulness, Becoming Mindful: Integrating Mindfulness into Your Psychiatric Practice is a concise and thoughtful book that promotes and guides the application of mindfulness in clinical practice.

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

Dr. Kyle Pruett is one of child and adolescent psychiatry’s most eminent members. Starting at a time when we only considered mothers important for a child’s well being, he taught our field, and our culture, how important fathers were. He has kindly agreed to share a bit about his evolution in the field and current understanding of “the other parent.”

~Alvin Rosenthal, MD, Features Editor

I mistrusted the influence of politics and competition in academic enclaves in my residency, so afterwards I decided to start a half-time private practice and devote the other half to working at a community-based, family-centered crisis intervention program for adolescents. Despite my six years of training at highly regarded residencies, I had never really learned how to interview a family rather than just a parent or a child or a parent-child dyad. Interviewing whole families during intake at this crisis clinic involved switching to a previously unused higher-powered lens on my clinical perception microscope. The verbal, and often contrasting non-verbal, conversations I saw bore little resemblance to descriptions I had heard from children or parents at interviews preceding the family session. I became aware of alliances, likenesses, identifications, and dislikes that no one had reported in individual interviews, often because they were unaware they existed. Furthermore, integrating this familial and individual information rendered treatment plans more effective and helped avoid expensive hospitalizations and re-hospitalizations, which the at-risk families this clinic served appreciated.

But sometimes one family member was missing: Dad. I realized that including the ‘other’ parent (when it was safe to do so) made interventions more effective – not just for the child. When both members of the parental coalition were heard, supported, understood, and engaged in treatment, the family system re-stabilized. The ‘other’ parent was usually the father (maybe biological, maybe not) though by no means the only active co-parents involved. Lesbian, gay parents, and cross-generational parents all participated and benefited as ‘other’ parents. That got me interested in why such engagement seemed effective. My child and adolescent psychiatry training had never insisted on both parents being involved in evaluation or treatment. Parents were “welcome,” but the intake form might have only one line on for “parent’s name.” That contrasted with what these other children were teaching me: They valued their relationships with both parents.

The late 1970s was also a time when millions of women were returning to work and many found themselves caring for their offspring, whether or not they wanted to. Could men care for an infant’s needs? Would infants suffer?

Fascinated, I designed a small pilot study of 20 intact families in which mothers were working. The fathers were out of work—by choice or circumstance—or worked from home and were providing the bulk of the infant’s care and nurture. I described my prospective study to a mentor at the Yale Child Study Center. “Kyle,” he said, “you’re at the beginning of your career and it would not help to start out with a failed study. Knowing what we know about attachment theory, what you are likely to find is delayed development due to maternal deprivation.” Was he right? I was not sure, so I did developmental assessments of these children (before they were 12 months old) and followed-up with repeat assessments a year later. Did fathers know what they were doing as parents? Would the children be off track developmentally as my mentor suggested?

Rather than deprivation, I found thriving, healthy, engaged infants. Moreover, the couples were satisfied with their children’s well being and often felt strengthened by the experience. However, most felt marginalized because they had stepped outside the mainstream-parenting highway. They often ran afoul of the institutions they interacted with about their children’s needs; educational, health, and, for the women and the men, marginalized professional identities. I had found that Dads could raise kids well but like most useful research, mine generated more questions than it answered. So, I started a part-time academic career to study it. (Pruett 1988)

The literature suggested that fathers (the 1980s most common form of ‘other’ parenting) supported their children in overlapping, if ‘non-maternal’ ways. Fathers were more likely to roughhouse with and activate their children; mothers tended to comfort, calm, and soothe. Father figures tended to spend more time playing with their children, while mothers spent more time caretaking or teaching. Fathers emphasized ‘real world’ implications of misbehavior, while mothers tended to emphasize emotional or relational consequences. Mothers tended to tip the playing field towards their children’s problem-solving success; fathers often let frustration mount to help build “the self-confidence that comes from figuring it out on their own.” Mothers tended to support “learning to speak for himself.” Secure attachments to mother provided comfort when the child is distressed, while fathers provided security through sensitive, challenging support during controlled excitement or when the child’s exploratory system was aroused. Of course, all behaviors can be observed in either parent. The trend is for fathers and fathering figures to bring slightly different skills and values to the nurturing domain.
Science tells us that, by and large, such a mix benefits their children (Pruett and Pruett 2008). Children parented by an engaged father enjoyed benefits in 1) educational outcomes: higher grade completion, math competence in girls, verbal strengths in boys and girls; 2) behavioral outcomes: reduced contact with juvenile justice, delay in initial sexual activity, less reliance on aggressive conflict resolution; and 3) emotional outcomes: greater problem-solving competence, stress tolerance, moral sensitivity, and reduced gender stereotyping (Pruett 2000).

Today, this news should no longer be news. Millennial parents are the first generation to expect paternal engagement as part of their co-parenting wish list (Zero to Three 2016). Since many parents lack role models for a shared vision of shared child rearing, it may not come naturally. But compelling evidence indicates that such engagement is good for children and parents. A father’s name on his child’s birth certificate lowered rates of infant mortality. Engaged fathers have increased longevity, reduced suicide and accidental death rates, and higher employment.

My research continues. In the past decade, many of these concepts have been successfully implemented and evaluated in the 900 plus families, randomized clinical trial, the “Supporting Father Involvement” project, which my wife Marsha Kline Pruett, PhD, and our Berkeley colleagues, Phil and Carolyn Cowan, have conducted. When fathers in at-risk families were positively engaged early in their children’s lives, many—if not most—risk factors for abuse and neglect were mitigated compared to controls.

Most research efforts investigating paternal variables pay it only lip service. Global literature search shows that in our journals, most articles that purport to measure father involvement, rarely report more than the father’s age, much less his level/quality or effects of his engagement with his child (Panter-Brick et al. 2014). Engaging the ‘other parent’ also makes trouble for many existing clinical systems. Gatekeeping is very common institutionally and theoretically, and promotes men’s absence in myriad ways that staff may be unaware of until they are encouraged and supported to do so.

To be father-friendly, one must 1) provide extended or at least alternate hours of operation to accommodate working fathers, 2) consider having a male presence on the staff, 3) make explicit intake procedures that expect he be present, 3) extend him a personal invitation/expectation to be involved and not simply invited by his spouse, and 4) when he’s a ‘no show’, consider rescheduling. Waiting areas, posters, and available reading materials often make fathers feel unwelcome. Will his needs be addressed as a father for things such as employment – the cornerstone of self-regard for so many men? Do billing practices mitigate for or against his presence? Staff needs to treat men as partners, not merely helpers, in the care and support of their children. Getting this right can help mobilize one of America’s greatest untapped resources in the lives of its children.

References


Pruett KD (2000). *Fatherneed: Why Father Care is as Essential as Mother Care for Your Child.* New York: Broadway Books


Dr. Pruett is clinical professor of Psychiatry and Nursing at Yale Child Study Center where he has served as director of Medical Studies and been awarded its Lifetime Teaching Award. He served as co-principal investigator of the award-winning Supporting Father Involvement Study for California Office of Child Abuse Prevention. He may be reached at kyle.pruett@yale.edu.
Pay Your Dues Online

Save time by renewing for 2017 online at www.aacap.org.

Follow these three easy steps!

2. Click on the Pay Dues Online at the bottom of the homepage.
3. Pay your dues!

It’s that easy!

In Memoriam

Humberto Quintana, MD
The Woodlands, TX

Edward Sperling, MD
New Rochelle, NY

Joel Stein, MD
Neptune Beach, FL

Is Renewing Stressing You Out?

Relax! AACAP offers flexible payment solutions to meet your needs.

Make life easier. Take advantage of our monthly installment payment program. Contact Member Services at 202.966.7300 ext. 2004 to discuss your personalized payment plan options.

Step 1:
Search “AACAP” in the Play Store or App Store

Step 2:
Download the AACAP app

Step 3: Bask in wonder at the tools you now possess
Each section of the AACAP app brings you different benefits.

- Events
- News
- Social

More

- Personalized event schedule
- Indexed list of speakers
- Session evaluations at a tap
- Connect feature—reach out to attendees
- Members in the News
- AACAP NewsClips
- Highlights
- Current AACAP Awards
- AACAP’s newest resources
- Never miss a deadline!
- Shortcut to AACAP Facebook page
- Shortcut to AACAP’s benefits including JAACAP, MOC
- Practice Parameters
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 January 1, 2017 to February 28, 2017

$1,000 to $4,999
Where Most Needed
General Contribution
Justice Ledro, MD

$500 to $999
Break the Cycle
Paul Croarkin, MD*

Campaign for America’s Kids
Lewis Sprunger, MD
Mental Health Addiction and Retardation
Organizations of America, Inc.

Elaine Schlosser Lewis Fund
Andrew Tananbaum*

Life Members Fund
Cynthia Pfeffer, MD
Martha Collins, MD, MPH

$100 to $499
Break the Cycle
Kyle Pruett, MD* Carol Rockhill, MD*

Campaign for America’s Kids
Carol Ann Dyer, MD
Wajitha P. Karatela, MD
Shoshanna L. Shear, MD
Michael S. Greenbaum, MD
Martin J. Drell, MD

Life Members Fund
Herschel D. Rosenzweig, MD
Stephen Wood Churchill, MD
John E. Dunne, MD
Quentin Ted Smith, MD
Harvey N. Kranzler, MD
James A. Ruggles, MD
Andrew Cook, MD
Phillip L. Edwardson, MD
The Renfrew Center of Miami

Paramjit Toor Joshi, MD International Scholars Award
Renuka N. Patel, MD

Where Most Needed
General Contributions
Anthony H. Jackson, MD
Martina E. Banegas, MD
Alan A. Axelsson, MD
Charles W. Popper, MD
Amazon Smile Foundation
Ibis Dalia Sigas, MD
Marcia E. Leikin, MD
Ibrahim Orgun, MD
Kristie Ladegard, MD
Sniguole Radzviciene, MD*
Natalie Velasquez, MD*
Matthew N. Koury, MD, MPH♥

Up to $99
Break the Cycle
Basil Bernstein, MD

Campaign for America’s Kids
Shetaly Mahesh Amin, MD
Barbara Burr, MD
Kirk C. Lum, MD
Eric S. Millman, MD
Jeffrey London, MD
Martha H. Aaron, MD
William Taylor, MD
Robertta Huberman, MD
Stuart Goldman, MD
Murat Pakyurek, MD*
Paula Marie Smith, MD♥
Alan Mark Ezagui, MHCA

General International Fund
Steven P. Cuffe, MD♥
Stuart Goldman, MD
Ashok Khushalani, MD

Life Members Fund
Florence Levy, MD
Ibrahim Orgun, MD
Boris Rubinstein, MD♥
Hector R. Bird, MD♥
Frederick N. Webber, MD♥
Gloria Berkvits, MD
Alan Mark Ezagui, MHCA♥

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

Where Most Needed
General Contributions
Jane C. Smith, MD
Shashi Motgi, MD
Richard Nightingale, MD
Wendy S. Levine, MD
Leslie Susan Dixon, MD
Stephanie Hartbelle, MD*
George Drinka, MD♥
Stephen J. Cozza, MD♥
Marco Annes, MD
Susan M. Toccheri, MD
Reebschack, MD
Odalsy Brito, MD
Mini Tandon, DO♥
Ryan Herring, MD, PhD♥
Howard Demb, MD
Daniela Davis, MD*

1953 Society Members
Anonymous (5)
Steve and Babette Cuffe
James C. Harris, MD and
Catherine DeAngelis, MD
Paramjit T. Joshi, MD
Joan E. Kinlan, MD
Dr. Michael Maloney and
Dr. Marta Pisarska
Jack and Sally McDermott
(‘Dr. Jack McDermott, in memoriam’)
Patricia A. McKnight, MD
Scott M. Falyo, MD
The Roberto Family
Diane H. Schelty, MD
Gabrielle L. Shapiro, MD
Diane K. Shrier, MD and
Adam Louis Shrier, Deng, JD

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

ERRATA from January/February issue of AACAP News:

Magda Campbell, MD, made a donation to the Virginia Q. Anthony Fund in the $1,000 to $2,499 range

Joel Zrull, MD, donated $500 to the Life Members Fund in memory of Dr. Jack McDermott

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. 140.
Attention Deficit Hyperactivity Disorder (ADHD) is a condition where people have difficulty with inattention, hyperactivity, impulsivity, regulating their mood and organization. For example, a child or teen with ADHD may have trouble in school and home with paying attention, concentrating, losing things, following directions, sitting still, acting without thinking or getting mad and frustrated easily.

**ADHD is a brain disorder.** Scientists have shown that there are differences in the brains of children with ADHD and that some of these differences change as a child ages and matures.

**Brain Structure**
Research has shown that some structures in the brain in children with ADHD can be smaller than those areas of the brain in children without ADHD.

The brain is an organ that controls thinking, feeling and behavior. The brain is divided into sections called lobes.

The front of the brain behind the forehead is the frontal lobe. The frontal lobe is the part of the brain that helps people to organize, plan, pay attention and make decisions. Parts of the frontal lobe may mature a few years later in people with ADHD.

The frontal lobe is the area of the brain responsible for:

- Problem Solving
- Memory
- Language
- Motivation
- Judgment
- Impulse control
- Social behavior
- Planning
- Decision-making
- Attention
- Ability to delay gratification
- Time perception
Networks

The brain is made up of nerve cells called neurons that transmit signals in the brain. Signals travel through the brain in groups of nerve cells called “networks”. Researchers have identified several major networks that work differently in people with ADHD. These networks are involved in reward, focus, planning, attention, shifting between tasks and movement.

Neurotransmitters

There are chemicals that help to transmit signals from one nerve cell to the next throughout the networks in the brain. These chemicals are called neurotransmitters. Dopamine and norepinephrine are two neurotransmitters that may play a role in ADHD.

While scientists have shown that there are differences in the brain size, networks, neurotransmitters and brain development of children with ADHD, they do not don’t fully understand how these differences lead to the cause and the symptoms of ADHD. Treatments for ADHD are thought to work in part by altering the levels of the neurotransmitters and changing how the networks function.

If your child has problems with attention, hyperactivity, or impulsivity, talk to your pediatrician or family doctor. They can perform an evaluation and start treatment or help with a referral to a qualified mental health professional.

For additional information, see Facts for Families:

- DHD
- Psychiatric Medication for Children & Adolescent
  Part I: How Medications Are Used
- Psychiatric Medication for Children and Adolescent
  Part II: Types of Medication
- Psychiatric Medications for Children and Adolescents
  Part III: Questions to Ask
- Comprehensive Psychiatric Evaluation
- Psychotherapy For Children and Adolescents
- School Services for Children with Special Needs:
  Know Your Rights
- Teen Brain: Behavior, Problem Solving, and
  Decision Making
- Advocating for Your Child
- Psychotherapies for Children and Adolescents
- College Students With ADHD
- Medication: Preventing Misuse and Diversion


##

If you find Facts for Families® helpful and would like to make good mental health a reality, consider donating to the Campaign for America’s Kids. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to Campaign for America’s Kids, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,700 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

Facts for Families® information sheets are developed, owned and distributed by AACAP. Hard copies of Facts sheets may be reproduced for personal or educational use without written permission, but cannot be included in material presented for sale or profit. All Facts can be viewed and printed from the AACAP website (www.aacap.org). Facts sheets may not be reproduced, duplicated or posted on any other website without written consent from AACAP. Organizations are permitted to create links to AACAP’s website and specific Facts sheets. For all questions please contact the AACAP Communications and Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

Copyright © 2017 by the American Academy of Child and Adolescent Psychiatry.
POLICY STATEMENTS

Policy Statement Procedures

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

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

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

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

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

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

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

AACAP Policy Statement Requirements

Policies should:

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

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

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

*revised 10/2012
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.

NOW FEATURING...

**JobSource FEATURES**

- Search for jobs by EMPLOYER, POSITION, LOCATION
- Create job alerts on what’s most important to you
- Save jobs to apply at your convenience
- Access career development materials
- Easily update and manage your online profile
- Upload your resume and build your profile
CLASSIFIEDS

DISTRICT OF COLUMBIA
CHIEF, DIVISION OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Job Description:
Children’s National Health System (CNHS) in Washington, DC 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 MD degree or both MD and PhD 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 Villongo, 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, MD, 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
CHILD AND ADOLESCENT PSYCHIATRIST – ST. LOUIS, MO

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

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

Company: Mercy (883968)
Job ID: 8535587
jobsource.aacap.org/jobs/8535587

NEW JERSEY
LUCRATIVE OUTPATIENT CHILD PSYCHIATRIST OPPORTUNITY IN NORTHERN NEW JERSEY

Job Description:
ADHD, Mood and Behavior Center is in search of the right board certified or eligible child psychiatrist to join our state-of-the-art, multi-disciplinary, private, fee-for-service, outpatient psychotherapy Center in Cedar Knolls, New Jersey. This child psychiatrist candidate will join our team of child, adolescent and adult psychiatrists, clinical psychologists, licensed clinical social workers and learning consultants, providing the exceptional level of care that our Center is widely known for and that our clinicians have received awards and high honors for. Responsibilities will include performing psychiatric evaluation, psychopharmacologic treatment and, if desired, psychotherapy, for the children, adolescents, young adults, families and adults referred to our Center. A strong administrative staff is always present to...
open and close the Center daily; greet our patients and their families; provide for all the clinicians’ administrative and clerical needs, including managing all scheduling, payments, chart maintenance; making calls to patients, pharmacies, collaborating physicians and therapists; managing all incoming and outgoing messages, prior authorizations and letters and reports, and more. The Center’s new child psychiatrist will practice in a spacious professional office, in our modern outpatient Center, in a luxurious office building, with abundant parking availability. Our Center is situated in an affluent area of northern New Jersey, adjacent to Morristown, less than an hour by car or train from NYC, and easily accessible from several major thoroughfares. This offer is for the serious candidate who shares our philosophy of excellence in patient care and our business model of generous reward for productivity. Qualified, interested candidates looking to join a cohesive group of highly trained professionals, providing high quality care and receiving the highest in financial compensation, should contact the Center, with accompanying cv, at abbazn@aol.com.

**Job Requirements:**
Board certified or board eligible in Child and Adolescent Psychiatry. Clinical experience in outpatient private practice setting preferred. Graduating child psychiatry fellows will also be considered. All necessary licenses and registrations, including New Jersey State Medical License, DEA, CDS-All current and active.

**Company:** ADHD, Mood and Behavior Center (980325)
**Job ID:** 8717766
**jobsource.aacap.org/jobs/8717766**

**GROUP PRACTICE IN AFFLUENT COMMUNITY SEEKING A QUALIFIED BC/BE CHILD AND ADOLESCENT PSYCHIATRIST**

**Job Description:**
If you are interested in becoming a part of a dynamic, cutting edge, multi-disciplinary team - then strongly consider this full time opportunity. The chosen candidate will become part of a extremely talented, well known team of clinicians from all disciplines of mental health. This is a fee for service practice not dependant on managed care. Job responsibilities will include performing Psychiatric evaluations, medication management, and psychotherapy if interested. Possible clinical research opportunities. BHC offers a supportive and respectful environment for our professionals and staff. This philosophy is rejected in the clinician and support staff retention rate. The practice has a full time office staff responsible for making appointments, taking messages and collecting fees. There is an integrated Electronic Medical Record system with e-prescribing that can conveniently be accessed remotely. In this way our providers experience a setting where one's energies can be focused on patient care instead of administrative distractions. Our center is located in a densely populated, affluent suburban community in scenic New Jersey. Livingston is approximately 25 miles from NYC and 15 miles east of Morristown, NJ. We offer a very attractive financial package including a strong income and medical benefits. Work hours are flexible and psychiatric coverage is easily accommodated within our group practice. Be part of a team that provides high quality services in a comfortable family like practice. We are seeking a skilled individual who can flourish in the kind of setting that BHC strives to maintain for professionals and our patients as well.

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

**Company:** Bartky HealthCare Center (1005298)
**Job ID:** 8833446
**jobsource.aacap.org/jobs/8833446**

**NEW YORK**

**PART TIME PSYCHIATRIST**

**Job Description:**
ANDRUS nurtures social and emotional well-being in children, families and the community by delivering a broad range of vital services and by providing research, training and innovative program models that promote standards of excellence for professional performance in and beyond our service community. The ANDRUS Campus Clinical program is searching for a Part Time Psychiatrist. The Psychiatrist provides psychiatric services to children and families. The Part Time Psychiatrist is under the supervision of Chief of Psychiatry. The position will entail 24 hours a week and the schedule is flexible. Minimum Requirements: Current New York State Physician License and DEA registration, plus board certification in child and adolescent psychiatry. Experience in child and adolescent psychiatry. Excellent analytical and clinical skills to resolve complex clinical and diagnostic problems. Strong computer skills with knowledge of EMR. Must have excellent oral and written communication skills. Ability to meet session productivity standards. Ability to travel and possess a valid driver’s license.

**Physical Requirements:**
Reach, Walk, Climb Stairs, Bend

All interested and qualified candidates please send your resume with a cover letter and salary requirement to ANDRUS HR-JP Department, 1156 North Broadway, Yonkers, NY 10701 or email to andrusjobs@jdam.org or fax to 914-965-3883.

**ANDRUS (1019407)**
**Job ID:** 8756628
**jobsource.aacap.org/jobs/8756628**

**RESIDENCY PROGRAM DIRECTOR**

**Job Description:**
The Child Study Center / Department of Child and Adolescent Psychiatry at NYU Langone Medical Center is currently seeking a Residency Program Director for the Child and Adolescent Psychiatry residency training program at NYU, Bellevue Hospital Center, and Rockland Children’s Psychiatric Center. As one of the oldest and largest child psychiatry residency training programs in the country, NYU / Bellevue / RCPC has an international reputation for excellence in training and provides residents with a wide range of clinical, research, and educational experiences in both public and private hospitals, clinics, and schools. Reporting to the Vice Chair for Education, the Residency Director will have primary responsibility for program development and continued on page 98
supervision of approximately 20 residents. The individual in this position is also responsible for bringing innovation and creativity into the training program through such means as resident and faculty retreats, resident research, and scholarly projects. Specific responsibilities include but are not limited to: Recruiting, interviewing and selecting residents Providing didactics and clinical supervision Supervising residents on the OMH telepsychiatry service Maintaining compliance with ACGME requirements and representing the department on Graduate Medical Education committees Defining, updating, and planning the resident curriculum and clinical rotations Supervising the education faculty of the department and all attending physicians and psychologists who teach residents at affiliated sites Regular review of resident achievement Monitoring resident progress toward successful matriculation Providing mentorship for residents Planning and supervising medical student electives Supervising the chief residents, residency coordinator and the Associate Residency Directors at NYU, Bellevue, and RCPC. For consideration, please send your CV to Ursula.Diamond@nyumc.org

Job Requirements:
This position requires an MD who is board certified in Child and Adolescent Psychiatry and possesses a minimum of 5 years of relevant experience. A clear track record of leadership and administrative experience, and demonstrated history of expertise in education and training are also required.

Company: NYU Langone Medical Center (1020954)
Job ID: 8776245
jobsource.aacap.org/jobs/8776245

PENNSYLVANIA
CHILD AND ADOLESCENT PSYCHIATRY – EASTERN PENNSYLVANIA

Job Description:
We invite a BC/BE Psychiatrist to join a Child and Adolescent Psychiatry practice consisting of four collegial Psychiatrists and three Advanced Practice Clinicians. The group is supported by counselors, social workers and nurses. This position will share responsibility for a 13 bed inpatient unit, a partial hospitalization program, outpatient clinics and consultations for department of pediatrics. We are offering competitive salary, outstanding benefits, and an academic appointment with our medical school partner - the University of South Florida. We are growing the Department of Psychiatry which currently comprises more than 20 Psychiatrists and 120 mental health professionals. LVHN Behavioral Health provides a full continuum of care in behavioral health from emergency evaluation to intensive care, partial hospitalization, outpatient follow-up, homecare and skilled nursing facility consultation. Lehigh Valley Health Network (LVHN) is a nonprofit community hospital system with over 1,300 beds across 5 full service hospital campuses, 160 practices and 1,500 medical staff providers. U.S. News & World Report has ranked LVHN among America’s Top Hospitals for 21 consecutive years and currently has two of our hospital campuses ranked in the top 20 hospitals in the State of Pennsylvania. We are dedicated to learning and have 20 fully accredited, free standing residency and fellowship programs while providing an innovative medical school program. Our nursing staff recently achieved its fourth consecutive Magnet status designation. We are located in the beautiful Lehigh Valley, a fast growing region in eastern Pennsylvania comprised of three mid-sized cites surrounded by suburban neighborhoods with over 700,000 residents. The area has a moderate cost of living, outstanding public and private school systems, ten colleges and universities, and an abundance of cultural and recreational offerings including two symphonies, summer music festivals, an art museum, and minor league sport teams. Just a 60 min drive north of Philadelphia and 90 min drive west of New York City. Email CV to the attention our new Chairman of the Department of Psychiatry – Edward Norris, MD c/o Mark.Payson@LVHN.org or call (484) 862-3205. Visit our website at www.LVHN.org.

Company: Lehigh Valley Health Network (1018150)
Job ID: 8738876
jobsource.aacap.org/jobs/8738876

WELLSPLAN HEALTH
PHILHAVEN CENTER FOR AUTISM AND DEVELOPMENTAL DISABILITIES (CADD)

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

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

- Learn the skills necessary to be a psychiatric leader in this rapidly changing field.
- Spend the year embedded in the rich learning environment of CADD’s multidisciplinary team.
- Learn how to incorporate applied behavior analysis in your psychiatric practice.
- Broaden your expertise with rotations in pediatric neurology, genetics and primary care consultation.

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

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

Director: Michael Fueyo, MD
Contact: Vicki R. Daniel, MBA
Director of Operations, CADD 1886 Rohrerstown Road Lancaster, PA 17601 (717) 735-920 x6012 vdaniel2@wellspan.org
Lifelong Learning Modules
Earn one year’s worth of both CME and self-assessment credit from one ABPN-approved source. Learn from approximately 35 journal articles, chosen by the Lifelong Learning Committee, on important topics and the latest research. Visit www.aacap.org/moc/modules to find out more about availability, credits, and pricing.

Improvement in Medical Practice Tools
(FREE and available to members only)
AACAP’s Lifelong Learning Committee has developed a series of ABPN-approved checklists and surveys to help fulfill the PIP component of your MOC requirements. Choose from over 20 clinical module forms and patient and peer feedback module forms. Patient forms also available in Spanish. AACAP members can download these tools at www.aacap.org/pip.

Live Meetings (www.aacap.org/cme)
Pediatric Psychopharmacology Institute — Up to 12.5 CME Credits
Douglas B. Hansen, MD, Annual Review Course — Up to 18 CME Credits
Annual Meeting — Up to 50 CME Credits
• Annual Meeting Self-Assessment Exam — 8 self-assessment CME Credits
• Annual Meeting Self-Assessment Workshop — 8 self-assessment CME Credits
• Lifelong Learning Institute featuring the latest module

JAACAP CME (FREE)
One article per month is selected to offer 1 CME credit. Simply read the article, complete the short post-test and evaluation, and earn your CME credit. Up to 12 CME credits are available at any given time. Visit www.jaacap.com/cme/home for more information.
ADVERTISING RATES
Inside front, inside back or back cover . . . $4,000
Full Page . . . . . . . . . . . . . . . . . . . . . . . . . $2,000
Half Page . . . . . . . . . . . . . . . . . . . . . . . . . $1,600
Third Page . . . . . . . . . . . . . . . . . . . . . . . . . $1,100
Quarter Page . . . . . . . . . . . . . . . . . . . . . . . $700

CLASSIFIED ADVERTISING RATES
$350 for 100 words
$375 for 150 words
$400 for 200 words
$425 for 250 words
$450 for 300 words
$475 for 350 words
$500 for 400 words
$525 for 450 words
$550 for 500 words

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

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