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Seattle, WA
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The Mission of the American Academy of Child and Adolescent Psychiatry is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

– Approved by AACAP Membership December 2014

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The American Academy of Child and Adolescent Psychiatry’s role is to lead its membership through collective action, peer support, continuing education, and mobilization of resources. The Academy

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

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

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

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

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2. Education regarding child and adolescent psychiatry.
3. Recording the history of AACAP.
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I’m Sad! Are You Happy?

Michael A. Shapiro, MD

During my first year of fellowship, I was attempting to engage a 14-year-old girl in therapy. Three months earlier, she had been admitted to our psychiatric hospital after posting a suicide note on a social media website. Her family had been totally caught off-guard by the possibility that the straight-A, straight-laced, eighth grader was severely depressed. I came to understand the surprise: she hid it well. How are you? “Good” she said while smiling. How’s school going? “Fine.” Smile. How are things at home? “Good.” Smile. All smiles, no problems. I knew she was hiding things that desperately needed to come to the surface. The social media post was more revealing than the first month of therapy sessions. I kept trying to imagine her reading it out loud during an appointment, that I kept trying to imagine her reading it than the first month of therapy sessions. She needed to come to the surface. The social media post was more revealing than the first month of therapy sessions. I kept trying to imagine her reading it out loud during an appointment, that I kept trying to imagine her reading it than the first month of therapy sessions. She needed to come to the surface. The social media post was more revealing than the first month of therapy sessions.

Inevitably, she must have realized that I wasn’t giving up that easy. I perceived her as being less defensive as she would share stories with me, but still did not verbalize any emotions. How’s school? “Well, we had a pop quiz in geometry that I didn’t know about.” Smile. How’s home? “My new jacket is missing, and I think my sister took it. That’s nice.” Smile. It wasn’t really nice, that was not the honest feeling she had. But I didn’t know if she knew that, or if she knew that I knew. So I asked her: was it really nice? “Well, no.” Smile. So that was sarcasm? “Uh, yah.” Smile.

So what to make of her sarcasm? Normally I find sarcasm a perfectly acceptable language for communication from teens. In fact, the use of humor in therapy with adolescents has many advocates (Drell 2015; Prerost 1984). Adolescents often use “hostile aggressive humor” in initial psychotherapy encounters as a way to release negative emotions, and in fact doing so “allows for the release of impulses” and “can provide the inhibited youth with the atmosphere for personal growth.

But I ignored all that, or more likely did not know it. I considered her sarcasm a defense, and I was determined to pierce it and get this girl to more directly emote. The first months of therapy felt like teaching her the alphabet. “This girl in my class is spreading rumors about me, so that’s awesome.” Is it really awesome? How does it actually feel? “What do you mean?” Did it make you feel sad? Angry? “I don’t know … angry, I guess.” Can you say, ‘I felt angry?’ “Uggghh …

I felt angry.” Smile. “I thought I aced my Spanish mid-term, but I got a C. Yay!” Smile. So you’re happy about your C? “No!” Well, you said ‘yay’ and you are smiling, that usually means somebody is happy. “Ugh … My grade made me … upset.” Like you have an upset stomach? “No, not that.” Were you angry? “No, not that either.” Could it be … sad? “Yeah, I guess, just a little. No, not sad … just … disappointed.” Can we just call it sad? “Sure.” Smile. Could she do any of this without smiling? “No, I always smile.” Uggghhh (that was mine). The passive aggressive expression of her anger and self-doubt was getting to me. I wanted to make this girl cry (there’s that countertransference again). Genuine negative emotion that she could both experience and correctly name would be awesome.

And then one day she came into my office. Instead of plopping down in the chair with a burst of energy, she slowly slumped down. She did not make eye contact, she looked at her shoes. I could see that she was genuinely sad. She never looked like this before, and my initial reaction was genuine concern. What happened? She started to tell me, in between snifflies. “This morning … my sister took the car to school. My cat was in the driveway … she ran over my cat. It died.” I’m so sorry, I said instinctively. And then, very faintly, I could see

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that she was crying. There was a box of tissues on my desk that was easily within her reach, but they went unused. It was probably for about two seconds, although it felt longer.

And then I had a thought. The thought occurred to me that this is a real-time moment of negative affect. Could she now identify it? I shifted in my seat, finally prepared to speak. She must have known what was coming; we had been practicing her emotional alphabet for weeks. I was going to ask her how she was feeling. I started to say, “So, how are you feel-” when she finally looked up at me, stared me dead in the eyes, and angrily shouted, “I’M SAD THAT MY CAT DIED! OK?!?” Then her gaze returned to her shoes.

And there it was. I messed up. I knew immediately that I did something “wrong,” but I wasn’t quite sure what I did that was wrong. Isn’t she supposed to talk about her feelings? Metaphorically speaking, I felt the bump we just hit on our therapeutic car ride, time to look in the rearview mirror. Things were going smoothly, save for the dead cat. The patient was genuinely sad, I was genuinely empathic, and then … oh. That’s what happened. I stopped doing what a genuine human being would do and starting doing what I thought a therapist should do. In reviewing common mistakes by beginning therapists (Alshuler 1989), I would categorize my transgression as a “premature over interpretation.” The reasons for making such an error are usually either the therapist being uncomfortable with the patient’s issue or emotion, the patient being emotionally uninvolved, or the therapist needing reassurance about his theory and clinical work.

Then it suddenly hit me – how effectively do non-patients, adolescents no less, express how they feel anyway? Do people come home from work and tell their spouse, “My boss yelled at me and that made me sad”? Or “This kid at school made me angry today”? I don’t think people do that; they tell a story while they make facial expressions, use their tone of voice, or grunt or cry or yell – things that therapists are not supposed to do (I learned later that they can). Therapists are supposed to use their words to communicate about feelings, but my patient did not have to learn to be a therapist, and I did not have to teach her how to be a therapist. She just needed to be a 14-year-old girl, and I had forgotten that. I suddenly realized that words were not always the best, most efficient way of emotional communication, and the genuine emotion and crying this patient displayed was worth more than any words she could have chosen to say.

So I messed up, what to do about it? Research has noted that patients have better perception than their therapists at identifying countertransference (Delgado et al. 2015), and to acknowledge the real relationship with the patient, and to take responsibility, would be the most helpful. At the next appointment, I apologized to the girl for my actions the previous session, and that I realized it could have come across as insensitive. She sarcastically said, “Yah!” She still seemed upset, but then she moved on to telling me her next story. She continued to see me for the next four years through her high school graduation. I was fortunate that I had not blown it, but I also felt fortunate that this girl continued to trust me with her feelings, passions, and desires, and for finally allowing someone to understand her. I learned a very valuable lesson from her: sometimes a genuine human being is just what the doctor should have ordered.

References

Dr. Shapiro is assistant professor and clinical director at the University of Florida Child and Adolescent Psychiatry Clinic, Springhill Health Center; and medical director of the Inpatient Child and Adolescent Psychiatry Unity at the University of Florida Health Shands Psychiatric Hospital. He may be reached at mshapiro@ufl.edu.
Assessing Parental Awareness of Child Mental Health in China and Egypt: A Novel Approach to International Integrated Care

The World Health Organization attributes thirty percent of the non-fatal disease burden to mental disorder and estimates twenty percent of children and adolescents suffer from some mental health (MH) disorder worldwide. About half of the world’s population lives in countries with a psychiatrist to population ratio of less than 1 to 100,000 people and the number of experts in child MH are even less than that (Moonkin, World Bank Group and W.H.O., 2016). These figures indicate the necessity of integrating MH in primary care to reduce stigma, improve service delivery, and decrease MH global burden in the long term (Vigo et al., Lancet, 2016).

In 2009, we created the University of Chicago Behavioral Health Questionnaire (UCBHQ) for a pilot study in an immigrant population of a Chicago-suburb. The UCBHQ consists of 12 demographic questions and 24 behavioral health questions for parents/caregivers that focus on assessing the following: a) understanding of common MH terms such as depression, anxiety, ADHD, autism, etc.; b) beliefs about the etiology of MH problems; c) perceived barriers to receiving MH care for their children, such as, culture, religion, spiritual beliefs or the influence of media; d) the availability/access to MH care; and e) previous experience with MH, e.g., seeking MH services for self or family members or attending a MH workshop.

Native speakers translated and back-translated the questionnaire in Arabic for accuracy and both English and Arabic versions were used in the study. We found factors such as gender, education level, time in the U.S. and experience with MH problems in the family led to distinct differences in the understanding of MH problems, their etiology and comfort level in seeking care (Afzal et al., Transcult Psychiatr, 2017). Some of the sample questions from UCBHQ can be viewed in Table 1.

Concurrently, The University of Chicago opened a Center in Beijing which led to new opportunities for research and collaboration in Asia. The Wuhan University Medical Education Reform (WUMER) project was a university-wide initiative for comprehensive reform of their medical education, curriculum and methodology. In 2012, we partnered with Department of Pediatrics, Zhongnan Hospital of Wuhan University to complete a similar project as the one in Chicago. For cultural accuracy, two native Mandarin speakers translated and back-translated the UCBHQ in Mandarin-Chinese. So far, we have collected more than 1900 questionnaires from parents visiting Primary Healthcare Clinics for non-MH needs in Beni Suef Governate, located about 80 miles south of Cairo. These clinics are funded by the Ministry of Health, Egypt. The preliminary results are invaluable to providing an understanding of parental awareness around pediatric mental health needs, recognizing barriers and identifying areas for immediate and long-term interventions.

In China, we provided educational materials for parents in Mandarin after they participated in the aforementioned study. Subsequently, we presented on pediatric MH topics such as pediatric depression, anxiety, ADHD and catatonia for physicians including psychiatrists. We led the interdisciplinary case conference to review complex med-psych cases. The discussion allowed us to create new channels for advancement of integrative care.

Last year, we sponsored a 2-day MH workshop at the University of Chicago Center in Beijing. Our focus was to promote interdisciplinary dialogue about raising MH awareness. We were very pleased with the level of participation and across different specialties of our Chinese counterparts on a variety of topics being presented by our faculty members.

Inspired by our studies in Illinois and China, our colleagues (see acknowledgments)* in Egypt expressed interest in pursuing a similar project there. Egypt is a country with a population of over 90 million in which children and adolescents constitute 38% of the total population. To accommodate the regional Arabic language differences, UCBHQ required minor modifications that were completed by native Egyptian Arabic language experts. So far, we have collected more than 1900 questionnaires from parents visiting Primary Healthcare Clinics for non-MH needs in Beni Suef Governate, located about 80 miles south of Cairo. These clinics are funded by the Ministry of Health, Egypt. The preliminary results are invaluable to providing an understanding of parental awareness around pediatric mental health needs, recognizing barriers and identifying areas for immediate and long-term interventions.

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Khalid I. Afzal, MD, and Karam Radwan, MD

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Kolko and Perrin identified familiarity and access to primary healthcare providers and lack of perceived MH stigma as desirable factors for integrated care, and we hypothesize that the high participation rate in our samples was likely linked to the surveys being offered in primary care settings (Kolko and Perrin, J Clin Child Adolesc Psychol, 2014). As opposed to the existing emphasis on prevalent related and intervention focused studies in pediatric primary care (Asarnow et al., JAMA Pediatr 2015; Kolko et al., Pediatrics, 2014), our approach was novel in assessing parents/caregivers awareness of their children’s and adolescents’ MH needs. Identifying barriers and strengths in families can facilitate highly individualized care with a potential impact on long-term treatment adherence. Furthermore, such an approach is both time and resource efficient especially in low and middle-income countries, and likely to empower, encourage and motivate primary care providers to strengthen their role in MH delivery and enhance integrated care.

Current demographic trends speak to the implications and significance of this questionnaire and our study here in the U.S. Pew Research Center estimates that this country will not have a single racial or ethnic majority by the year 2055 (Cohn and Caumont, Pew Research Center, 2016). This increasingly diverse population will pose unique challenges to MH providers in keeping themselves culturally informed about distinct psychiatric presentations, attitudes towards MH care, and service delivery. Partnering with primary care providers in parent/caregiver-focused projects similar to ours may offer to:

a) Assess parental awareness of pediatric MH in cultural and ethnic cohorts
b) Identify barriers to receiving MH care
c) Recognize areas of strength and resilience; and,

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<td>Behavioral or mental health conditions are caused by chemical imbalances in the brain:</td>
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<tr>
<td>Strongly agree</td>
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<tr>
<td>Behavioral or mental health conditions are caused by nutritional deficiencies:</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>If yes, which nutritional deficiencies?</td>
</tr>
<tr>
<td>Behavioral or mental health conditions are present only in Western cultures and not in Eastern cultures:</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>Behavioral issues in children are part of mental health:</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>Behavioral issues in teenagers are part of mental health:</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>Problems in mathematics, reading or writing are considered to be a part of behavior or mental health in children:</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>I am comfortable in seeking help for behavioral or mental health needs of children:</td>
</tr>
<tr>
<td>❑ Yes</td>
</tr>
<tr>
<td>My SPIRITUAL/RELIGIOUS beliefs allow me to seek help for behavioral or mental health needs of my child:</td>
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<tr>
<td>❑ Yes</td>
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<tr>
<td>My CULTURAL beliefs allow me to seek help for behavioral or mental health needs of my child:</td>
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<td>❑ Yes</td>
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d) Develop individualized MH interventions in primary healthcare settings.

Acknowledgements
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References


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Expand Your Power With an AACAP Advocacy and Collaboration Grant

Want to strengthen your ROCAP’s impact on state and local issues? Apply for AACAP’s Advocacy and Collaboration Grant. If approved, you can use the funds to start something that may well grow into something inspirational. In 2008, the California Academy of Child and Adolescent Psychiatry received it’s AACAP Advocacy and Collaboration Grant. We used the grant to offset costs of a two-part joint advocacy program with Cal NAMI. We began having advocacy collaboration conferences in the fall where physicians met with patients, families, and advocacy groups to discuss what was working and what wasn’t working in mental health delivery in California. Although we had different backgrounds, we discovered that we shared a lot of the same concerns and hopes for the future. For many, it was the first time for psychiatrists to meet patients or family members outside of a treatment setting. This turned out to be empowering for individuals of both organizations and a stronger, unified voice when we met the following spring to advocate together at our state capitol for bills we supported.

The success of that event led us to invite another organization to join us the following year. United Advocates for Children and Families became our new allied collaborator. The second year was inspiring and uplifting as well. We’re now in our ninth year of advocacy and collaboration with other groups. Some, like Cal NAMI, have remained with us every year, while others have not been able to continue with us. We were fortunate enough to receive the grant for three years in a row. It was a lifeline to the early stages of our program, as charging a fee to attendees would have discouraged attendance, and spending members’ money on an unproven activity would have been risky. Now we have not only a set of annual events, but we have friends and allies across the state who frequently join us in supporting or opposing measures that impact mental health.

The recipients of AACAP’s 2017 Advocacy and Collaboration grants have some great ideas. Tampa Bay Council of Child Psychiatry is working with the University of South Florida’s Department of Child and Adolescent Psychiatry to educate Hillsborough County Schools about emergency assessments and after-care programs to better utilize services and reduce involuntary assessments. Tennessee Academy of Child Psychiatry is tackling stigma associated with mental illness with a film. Washington State Council of Child and Adolescent Psychiatry is planning a spring listening event with legislators followed by a fall forum to continue engaging with legislators to find ways to improve the state’s mental health treatment system. Louisiana Council of Child Psychiatry is establishing an Autistic Spectrum Disorder program at the Children’s Hospital of New Orleans. The funds will help them educate the community about services offered. The Michigan Council of Child Psychiatry is planning a joint meeting with the Michigan Chapter of the American Academy of Pediatrics to discuss topics of interest to both pediatricians and child psychiatrists.

There are many ways to advocate, many ways to collaborate, and many ways to create strong partnerships for a better future. Be creative and let your passion drive you. Who knows, you may just start something big. Look at AACAP’s website (http://www.aacap.org/App_Themes/AACAP/Docs/Advocacy/how_to_be_an_advocate/2018-Application-and-Guidelines.pdf) as soon as possible for instructions to apply for a grant by the deadline of January 5, 2018, and start your plans.
Approximately one percent of the world’s population, are currently uprooted, with 22.5 million refugees seeking safety in another country and 65.6 million people forcibly displaced worldwide (UNHCR, 2017). A refugee is a person who lives outside his/her country of nationality and unable to return due to persecution of race, religion, nationality, membership of a particular social group or political opinion. Over half of the world’s displaced population are children. The stresses to which most refugees are exposed can be thought of in different stages of their lives – (1) from their home country of origin, then (2) during the migration flight to safety, and (3) to the resettlement period in a host country. In their home countries, many youth have been forced to flee their homes due to war exposure or armed conflict and have therefore witnessed violence, torture, traumatic loss of loved ones, and separation from friends and school. Parental distress is common, along with general feelings of insecurity. Migration can also pose dangers with separation from family, unstable sources of food or housing, and potential for trafficking or sexual violence. The post-migration phase of resettlement can often be referred as a period of “secondary trauma,” as youth struggle to adapt to a new culture, language, peer group, as well as acculturative stress and generational stress with their parents or caregivers. With globalization and the recent wars in Syria, Afghanistan, and Iraq, as well as the conflicts in central America’s northern triangle (El Salvador, Guatemala, Honduras), we have more refugees and unaccompanied minors landing in our backyards. The role of the child/adolescent psychiatrist becomes more prominent, as many will be asked to help the increasing number of war-affected youth locally and globally.


The war in Syria has reached intolerable levels of human suffering and despair. Hundreds of thousands of Syrians have been killed, hundreds of thousands have been trapped in besieged areas, and tens of thousands have been tortured. UNICEF estimates that some 8.4 million Syrian children, more than 80% of the Syrian child population, have now been affected by the conflict in Syria. The numbers of wounded survivors, many with amputations, severe burns, or paralysis, cannot yet be assessed; and at least 13 million Syrians have been forcefully displaced within Syria and into its neighboring countries.

Children living through wars and conflict suffer many consequences including post-traumatic stress symptoms, psychosomatic symptoms, depression, anxiety, disturbed play, and behavioral, emotional, and sleep problems, substance use, suicide risk, and physical disease risk. These mental health and physical risks following exposure to war and conflict are also seen among displaced populations and among refugees. War can have devastating effects due to effects on parents, survival needs, and harm to fundamental systems that nurture and protect child development. The greatest effects on

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Saving the Lost Generation
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These mental health and physical risks following exposure to war and conflict are also seen among displaced populations and among refugees. War can have devastating effects due to effects on parents, survival needs, and harm to fundamental systems that nurture and protect child development.

children occur when parents are killed, harmed, terrified, or unable to function, and when the child experiences violent harm to themselves or loved ones, threats of such violence, or engages in harming others.

I have found that the best practices for trauma recovery include: (1) Deep understanding of the Local Culture and Practices (Religion, Family structure), (2) Rebuild Social Networks (friends, school, neighbors, play, sport) that promote Support, Healing, Reconstruction, Self-worth, and Trust, (3) Re-establish a Sense of Normalcy, including Daily Routine of Family, Community, and Life (School, meals, Sport), and (4) Education and School: where schooling represent a state of normalcy, a chance to be with friends, and enjoy their support and encouragement, where they can develop new coping and survival knowledge that builds child’s personality, talents, physical and mental abilities to their fullest potential.

SAMS has established programs to provide treatment and care to the Syrian communities in Jordan, Lebanon, and inside Syria. Each program consists of Social Workers, Psychotherapists and Psychiatrists. Services Provided are:

Social Support: To facilitate Resilience, children need to be provided with a Stable environment, and a loving and nurturing community. SAMS outreach workers would make visits to the Syrian Families to: (1) Provide some families with food, especially in the besieged areas to prevent sexual exploitation of the children as price for their food, (2) Assess the family members for PTSD/ Depression, (3) Evaluate the need for any Medical Assistance and referring them to Medical professionals in the community, (4) Assist the children to pursue Education: we rent schools to provide the children with basic Education needs, and (5) Assist with Vocational Training for the Widows. Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime. (Chinese Proverb)

Therapy/Treatment: (1) Individual Supportive and Cognitive Behavioral Therapy, (2) Family Therapy (Supportive, Psychoeducational); for the parents whose children with symptoms of Depression, PTSD, behavioral troubles, bedwetting, and refusal to go to school, (3) Group Therapy (Cognitive, Behavioral, Supportive): for Mothers and Teenagers survivors of multiple losses and traumas, (4) Play/Art Therapy for young children, and (5) Medications: It is extremely difficult to provide medications to the inside of Syria due to Border’s Closure, especially in South Syria, close to Jordan. SAMS members have been trying to provide best treatment practices to the Syrian refugees, despite our limited budget and resources.

Dr. Yassar Kanawati is a board-certified child/adolescent and adult psychiatrist, with a focus on addiction psychiatry. She finished her psychiatry residency and fellowship at Wayne State University and is currently an Assistant Professor at Emory Medical School and Morehouse School of Medicine. Among her areas of expertise are depression and mood disorders, ADHD and disruptive disorders, and PTSD and the effects of trauma and war on family members. In November 2012, Dr. Kanawati visited Amman, Jordan, where she assessed the psychiatric needs of Syrian refugees with the support for the Syrian American Medical Society Psychosocial Support Team.

Dr. Suzan Song is Director, Division of Child/Adolescent and Family Psychiatry; Associate Professor, George Washington University Medical Center.
WOMEN’S COMMITTEE

Reflections on Pregnancy During Child and Adolescent Psychiatry Training and Practice

Elizabeth McGuire, MD, with Diane K. Shrier, MD

“You should name him Indiana Jones!” This was arguably the best suggestion for a baby name from one of my play therapy patients while I was pregnant during my child and adolescent psychiatry fellowship. My patient and I both had a love of the film adventurer and it was also clear that this child, whom I would end up seeing for nearly my entire fellowship, was genuinely excited by the news of my pregnancy. Nonetheless, I had fears that my pregnancy, and the artificial termination of our therapy due to my maternity leave, would lead to increased anxiety for my patient, who had already experienced abandonment by other parent figures earlier in life.

Although my husband and I ultimately chose not to use Indiana Jones as a name for our first son, I always remember my patient’s enthusiastic and cheerful suggestion as one of the most positive responses to my pregnancy, whether it was during my first pregnancy while in child and adolescent psychiatry fellowship or during my second pregnancy while working as a staff psychiatrist in a children’s mental health center. The most common reaction of the child patients in my practice, after initial surprise and interest in the details of the baby (e.g., gender, due date), was to then move on and ignore it (the pregnancy/baby) until the subject naturally came up in the final sessions prior to maternity leave.

Women child and adolescent psychiatrists can face particular challenges when we become pregnant in the course of our careers. Not only are we going to navigate the reactions of our child and adolescent patients to the pregnancy, but we must also experience the reactions of their parents/caregivers and of colleagues, supervisors, and others.

“Psychiatry as a career path can expose us to unpredictable individuals, and pregnancy itself can make the woman more of a target than she would be otherwise.”

Some patients or their families can be quite solicitous toward pregnant psychiatrists, including bringing gifts for the baby. I received baby gifts from more affluent patients and also from patients whose families struggle to make ends meet each month. Do the gifts change the dynamic of the patient-physician relationship? What about when the child or parents ask if the new baby enjoys the stuffed animal or the hand knit baby blanket? Again, without flexible culture-based guidelines, my own general policy was to keep the smaller, handmade gifts and donate some of the gifts that were still in boxes, thus continuing the spirit of generosity toward another family that has greater need than my own family.

While I was fortunate to have mostly positive responses to both of my pregnancies, I also experienced more challenging reactions. There was the child with autism, intellectual disability, and aggressive behaviors, who became inordinately focused on my growing abdomen, to the point that he would attempt to touch it during each appointment, and more than once tried to push me on my abdomen. One mother of a patient of mine suddenly became quite caring and maternal towards me, even while she continued to demonstrate abusive behavior toward her teenaged daughter. There was the young teen who herself became pregnant not long after I started showing for my second pregnancy. Despite the potential for a parallel process for us both, she ended up distancing herself over the ensuing weeks and months, to the point of making rude and dismissive statements to me at our last appointment before my maternity leave.

During both pregnancies, I found myself increasingly aware of potential safety concerns and wanting to limit intakes for children or adolescents who had a history of significant aggression. Even an increase in emotional hostility increased my anxiety about my own safety and that of my unborn child. Psychiatry as a career path can expose us to unpredictable individuals, and pregnancy itself can make the woman more of a target than she would be otherwise. Certainly, a practice’s particular patient population may also determine the typical range of responses to a pregnant psychiatrist. How differently would child patients respond if those children come from intact families and a position of privilege versus children who have experienced trauma, poverty, immigration, housing instability, and/or loss of one or both parents?

Not only do we have to consider the reactions of our child patients and their

continued on page 254
families to a pregnancy, but for those of us in a group practice or in a training program, we also have to consider how our colleagues may respond to a pregnancy. Will our colleagues resent us for needing to take time off for maternity leave? Will colleagues be supportive and helpful as we wind down practice in anticipation of leave, or will they continue to interact with us as if in denial, virtually ignoring the third person in the room – the baby? Just as pregnancy opens us up for questions from patients, it also may invite unwanted statements from other professionals regarding any aspect of our physical state, such as the size or shape of our abdomen, the weight we have gained, our energy level, or even touching our growing bellies without permission. Assumptions may be made about career-ending, post-partum plans and that the woman would be staying home and leaving the profession rather than making other child-care options. A recent informal poll in a social media post for a women psychiatrist group resulted in dozens of similar responses detailing unhelpful, critical, and incredibly personal remarks from colleagues or other staff toward women psychiatrists while they were pregnant.

There remains a remarkable paucity of large-scale research that might lead to more profession-wide recommendations based on data, rather than assumptions. Since a majority of child and adolescent psychiatrists are women, and most women complete training and early career during their childbearing years, more research is indicated in this important area to inform policy for residency training programs and beyond.

Dr. McGuire is a child and adolescent psychiatrist working at Child and Family Guidance Center in Northridge, California. She is a member of the Women in Child and Adolescent Psychiatry Committee and spends much of her free time chasing around her two young sons. She may be reached at emcguiremd@gmail.com.

Dr. Shrier is clinical professor of psychiatry and of pediatrics at George Washington University School of Medicine and has a private practice in Washington, DC. She may be reached at dianeshrier@rcn.com.

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

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

In 100 words or less, tell us who served as your mentor. Email submissions to communications@aacap.org by January 10, 2018.

Please include your name, affiliation (if appropriate), the name of your mentor(s), and a short testimonial or anecdote.
2018 will mark the 20th anniversary of the AACAP Physician Scientist Program in Substance Abuse, supported by the National Institute on Drug Abuse (NIDA). Supported with funds through NIDA Career Development Award (K12) first granted to AACAP in 1998, this longstanding and successful award provides up to five years of salary support, research support, and mentored addiction research training for qualified child and adolescent psychiatrists. Eighteen scholars completed this NIDA-AACAP program between 1998 through 2014, under the leadership of Program Directors, Bennett Leventhal, MD, of the University of California San Francisco (1998-2003) and Paula Riggs, MD, of the University of Colorado, Denver (2004-2020). Advisory Committee Chairs, Catherine Martin, MD, of the University of Kentucky College of Medicine (2004-2014), and Kevin Gray, MD, of the Medical University of South Carolina (2015-2020) assist in the administration of the K12 program.

The partnership between AACAP and NIDA is complimentary to each organization as both have a shared mission to:

- Increase the number of child and adolescent psychiatrist investigators conducting both addiction and mental health research; and
- Disseminate pediatric addiction research to increase scientific knowledge and improve clinical practice.

The K12 scholars have significantly contributed to the advancement of the field of child and adolescent addiction research and clinical practice. Together, K12 scholars have contributed more than 500 publications to the scientific and clinical literature. And, subsequent to their training, this productive group has obtained more than 35 new research grants to support their research.

In May 2015, AACAP received the fourth 5-year competing renewal (2015-2020) of the NIDA-AACAP K12. Six new scholars were selected and received their awards in 2016.

Alongside Drs. Riggs and Gray, Carmen J. Head, MPH, CHES, AACAP’s Director of Research, Grants & Workforce serves as the Program Administrator. Current K12 Advisory Committee members include leading researchers in substance use disorders and/or child and adolescent psychiatry: Dr. Leventhal, Frances...
The six current NIDA-AACAP scholars, listed below, have demonstrated remarkable progress and academic achievement at this early stage of their career, which predicts that they will soon join their predecessors as scientific leaders in the field.

Allan Andersen, MD, University of Iowa Carver College of Medicine  
Primary Mentor: Robert A. Philibert, MD, PhD  
Project Title: Tobacco and Cannabis Smoking Effects on Immune Function in Youth

Kara S. Bagot, MD, University of California San Diego  
Primary Mentor: Susan Tapert, PhD  
Project Title: Mobile Health Intervention for Adolescent Cannabis Use

Eraka Bath, MD, University of California, Los Angeles, David Geffen School of Medicine  
Primary Mentor: David J. Farabee, PhD  
Project Title: Commercially Sexually Exploited Youth in Specialty Courts: Examining Substance Use and Mental Health Problems and Adapting Emergent Technologies to Increase Engagement

Christopher Hammond, MD, PhD, Johns Hopkins School of Medicine  
Primary Mentor: Eliot Stein, PhD; Secondary Mentor: Robert Findling, MD, MBA  
Project Title: Neurobiological Change in Cognitive Control and Salience Brain Network Function after Substance Use Treatment Response in Adolescents with Cannabis Use Disorders

Roya Ijadi-Maghsoodi, MD, University of California, Los Angeles, Women’s Health, VA Greater Los Angeles Healthcare System  
Primary Mentor: Lillian Gelberg, MD  
Project Title: Strengthening Homeless Families With Parental Substance Abuse

Amy Yule, MD, Harvard Medical School and Massachusetts General Hospital  
Primary Mentor: Timothy Wilens, MD  
Project Title: A Randomized Controlled Trial of Quetiapine for the Treatment of Youth with Co-occurring Substance Use Disorders and Bipolar Disorder

Levin, MD, Dr. Martin, and Neal Ryan, MD. Scholars’ primary home institution research mentors provide year-round mentorship and participate as K12 program faculty during K12 annual retreats. The K12 annual retreats are held in June just prior to the College of Problems on Drug Dependence (CPDD) Annual Meeting. Retreats allow program participants to come together as a community of scholars and have, over time, fostered the development of a national network of research mentors.

The Annual K12 retreat took place in Montreal, Quebec, June 15-17, 2017. NIDA/AACAP scholars convened with their mentors, Dr. Riggs, and K12 Advisory Committee Members. Carmen J. Head, and AACAP’s Assistant Director of Research, Training, and Education, Sarah Hellwege, MEd, also attended and were instrumental to the planning and success of the retreat. The retreat program is specifically designed to develop core competencies and skills necessary to scholars’ successful academic career development. Scholars received feedback and guidance on their research presentations and posters from faculty mentors, fellow scholars, and the K12 Advisory Committee. Dr. Riggs presented strategies for recruiting adolescent research participants and Jane B. Acri, PhD, Chief, NIDA Medication Discovery and Toxicology Branch, presented on NIDA/NIH research funding priorities, highlighting specific resources and funding opportunities for early career investigators. The scholars led and facilitated two discussion forums addressing specific challenges faced by physician investigators, such as balancing clinical duties and research time.

NIDA has been justly proud of AACAP’s Physician Scientist Program in Substance Abuse. AACAP would like to congratulate AACAP’s K12 scholars and looks forward to their contributions to the field.
Get in the News!

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

Categories for submission and consideration are:

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

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

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

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

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

- **Newsworthy items**
  - Fully developed News Articles, 800-1500 words
  - Kudos, highlighting member achievements 250 words or less

- **Regional Organization of Child and Adolescent Psychiatry, 250 words or less**

- Committee activity reports or updates, 250 words or less

- **Features**, 600-1200 words
  - Interviews
  - Discussions of movies or literature
  - Creative Arts, e.g. poems, cartoons, drawings (limited to 1 page)

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Please consider a gift in your Will, and join your colleagues and friends:

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Anonymous (5)

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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. Palyo, MD

The Roberto Family

Diane H. Schetky, MD

Gabrielle L. Shapiro, MD

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

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

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

Alvin Rosenfeld, MD
Photo Editor, AACAP News
arosen45@aol.com

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OMYO A Brave Dinosaur

Written by Joan Stern Narad and Illustrated by Ken Shuey
North Cove Press 2017
Hardback: 30 pages – $14.95

Written by Joan Stern Narad, MD, a child and adolescent psychiatrist, OMYO A Brave Dinosaur tells the story of a young dinosaur placed in foster care and his journey to find a new “dinofamily.” Dr. Joan Stern Narad wrote this book for foster and adoptive children and their families, and has its origins in booklets she created as an inpatient psychiatrist. OMYO’s story captures the pain and struggle of trauma and early experiences of attachment as a young dinosaur is transferred from his birth home into foster settings. It is a story of hope, bravery, and the healing power of a caring and loving family. With playful writing and bright illustrations, OMYO A Brave Dinosaur is a captivating story for foster and adoptive children and their families.
Clara Schuman’s Loss and Love

By Mali Mann, MD

Virtuoso pianist, Clara, wife, but an untimely widow mother, whose unborn child never arrived, lost the ones who were her born ones too. Her pouring tears came like rain, words ran off in silence and, time travelled on.

Fleeting Eros flew over the curtains of cloud landed gently, circled above her chest. The longing gaze anchored in her eyes. The sad, tender and lavished intermezzi surrounded the pair like a circled arms composed new dreams, fears and longings echoed wild in her newly born sonata.

The imagining me envisions two like one in a warm July night, looking on shimmering stars. No one could be heard: the time was let to go. Rising rhythm of her fingers on highflying keys was made. Walking in the meadow in tiptoes, whispered not, their dream of one sonic world. Letting the late blooming roses only speak of love.
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.**

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

AACAP’s 65th Annual Meeting takes place October 22-27, 2018, at the Washington State Convention Center in Seattle, Washington. Abstract proposals are prerequisites for acceptance of any presentations. Topics may include any aspect of child and adolescent psychiatry: clinical treatment, research, training, development, service delivery, or administration.

Abstract proposals must be received at AACAP by **February 15, 2018**, or by **June 15, 2018**, for (late) New Research Posters. The online Call for Papers submission form will be available at [www.aacap.org](http://www.aacap.org) in December 2017, and all submissions must be made online.

Questions? Contact AACAP Meetings Department at 202.966.7300, ext. 2006 or meetings@aacap.org.
You’re Invited to Exhibit!

Don’t miss the chance to connect with specific demographics within the child and adolescent psychiatry community in 2018!

Tabletop exhibits are available at AACAP’s Pediatric Psychopharmacology Update Institute and are placed in high-traffic areas near the coffee break area or an area directly adjacent to the meeting room, providing exhibitors with a great opportunity to meet attendees. The vast majority of our attendees are practicing physicians.

Exhibit opportunities details are below:

2018 Pediatric Psychopharmacology Update Institute
Cutting-Edge Psychopharmacology: Fads vs. Facts?
Laurence L. Greenhill, MD, and Jeremy M. Veenstra-VanderWeele, MD, Co-Chairs
January 26-27, 2018
New York Marriott at the Brooklyn Bridge – Brooklyn, NY
Expected Attendance: 800+

The Invitation to Exhibit for AACAP’s 65th Annual Meeting, October 22-27, 2018, at the Washington State Convention Center will be mailed in May.

For more information, please visit www.aacap.org/ExhibitandSponsor or contact:

Katherine Chen
AACAP Meetings & Exhibits Manager
Phone: 202.966.9574
Fax: 202.966.5894
Email: exhibits@aacap.org

AACAP’s Newest Lifelong Learning Module Now Available

AACAP is proud to announce the release of Lifelong Learning Module 14: Relevant Clinical Updates for Child and Adolescent Psychiatrists. With the purchase of this module you will have the opportunity to earn 38 AMA PRA Category 1 Credits™ (8 of which will count towards the ABPN’s self-assessment requirement).

To order Module 14:

Online: Purchase via our online publication store at www.aacap.org.
By Fax/Mail: Download and print a publication order from www.aacap.org/moc.

For questions about Module 14 or maintenance of certification, please contact Elizabeth Hughes, Deputy Director of Education and Recertification, at 202.966.1944 or at ehughes@aacap.org.

SPECIAL PROMOTION
Order Module 14 when you pay your 2018 membership dues by January 31, 2018 and SAVE $60!

Look on your dues renewal form for more information.
Session Recordings and Notebooks are available for purchase from past and current AACAP meetings!

- Pediatric Psychopharmacology Update Institute
- Douglas B. Hansen, MD, Annual Review Course
- Annual Meeting Institutes and other sessions

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

Session recordings include PowerPoint slides. To order, please visit: aacap.sclivelearningcenter.com.

You can also contact:
Multiview Canada
50 Minthorn Blvd, Suite 800
Thornhill, ON L3T 7X8
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Phone: 972.402.7098
Fax: 905.889.6566

To order Notebooks:
Order online through the Publication Store at www.aacap.org.
2018
Pediatric Psychopharmacology Update Institute

Cutting-Edge Psychopharmacology: Fads vs. Facts?

THIS INSTITUTE SELLS OUT IN NEW YORK — REGISTER EARLY!

January 26-27, 2018
New York Marriott at the Brooklyn Bridge—Brooklyn, NY

Laurence L. Greenhill, MD, and Jeremy M. Veenstra-VanderWeele, MD, Co-Chairs

Register by December 12 at www.aacap.org/psychopharm-2018 for early bird rates.
Questions? Email meetings@aacap.org.
Pay Your Dues Online

Save time by renewing for 2018 online at www.aacap.org.

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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.
ACADEMY & ASSOCIATION 101

What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP's Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
2018 Association Membership

As you look to renew your dues for 2018, please join our 501(c)(6) Association, by not checking the box to opt-out on your dues invoice. As you may know, in 2013 the American Association of Child and Adolescent Psychiatry was formed as a closely affiliated organization of the Academy to house our advocacy efforts. Regardless of whether you opt-out of the 501(c)(6) Association, your dues will remain the same.

The 501(c)(6) Association expands AACAP’s government affairs and advocacy efforts by helping child and adolescent psychiatrists engage in health policy and advocacy activities that promote mentally healthy children, adolescents, families as well as the profession of child and adolescent psychiatry. The Association houses AACAP’s advocacy programs. These include federal lobbying through activities like the Legislative Conference, grassroots advocacy through AACAP’s Advocacy Liaison program, and AACAP-PAC. Please note that under federal law your dues dollars can never be used by AACAP-PAC to support political candidates, and membership in the Association is not the same as becoming a voluntary member of AACAP-PAC.

If you check the opt-out box in the 501(c)(6) special notice, you will be prohibited from receiving the free benefits of the Association. You will not be eligible to receive the Association’s resources for federal and state advocacy. Regardless of whether you opt-in or opt-out of the Association, your dues will be the same.

Throughout the year, the Association holds special events and provides informative updates on regulatory and policy proposals that may impact your practice, research, and patients. The Association, in tandem with the Academy, is here to provide our members with the best possible service. We look forward to having your continued membership in both the Academy and the Association in 2018!
AACAP Policy Statement

Marijuana Legalization

Revised Approved by Council May 2017

The American Academy of Child and Adolescent Psychiatry (AACAP) advocates for careful consideration of potential immediate and downstream effects of marijuana policy changes on children and adolescents. Marijuana legalization, even if restricted to adults, may be associated with (a) decreased adolescent perception of marijuana’s harmful effects, (b) increased marijuana use among parents and caretakers, and (c) increased adolescent access to marijuana, all of which reliably predict increased rates of adolescent marijuana use and associated problems.1-3. Marijuana use during pregnancy, occurring at increasing rates, raises additional concerns regarding future infant, child, and adolescent development.4-6

AACAP is aware that, among hundreds of chemical constituents, marijuana contains select individual compounds that, if safely administered in reliable doses, may potentially convey therapeutic effects for specific conditions in specific populations.7 Advocacy regarding potential cannabinoid therapeutics, alongside social justice, public policy, and economic concerns, have contributed to marijuana policy changes. Amid these factors, AACAP remains focused on concerns regarding adolescent marijuana use.

Adolescents are especially vulnerable to marijuana’s many known adverse effects.8,9 One in six adolescent marijuana users develops cannabis use disorder, a well characterized syndrome involving tolerance, withdrawal, and continued use despite significant associated impairments.9,10 Selective breeding has increased marijuana’s addictive potency and potential harm to adolescents.12 Heavy use during adolescence is associated with increased incidence and worsened course of psychotic, mood, anxiety, and substance use disorders.13,14 Furthermore, marijuana’s deleterious effects on adolescent cognition, behavior, and brain development may have immediate and long-term implications, including increased risk of motor vehicle accidents, sexual victimization, academic failure, lasting decline in intelligence measures, psychopathology, addiction, and psychosocial and occupational impairment.8,13-16

Marijuana-related policy changes, including legalization, may have significant unintended consequences for children and adolescents. AACAP supports (a) initiatives to increase awareness of marijuana’s harmful effects on adolescents, (b) improved access to evidence-based treatment for adolescents with marijuana-related problems, and (c) careful monitoring of the effects of marijuana-related policy changes on child and adolescent mental health. Finally, AACAP strongly advocates for the involvement of the medical and research community in these critical and highly impactful policy-related discussions.


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

Policy Statement Procedures

» Once a final draft policy statement is submitted by an individual author(s) or body (e.g., component or Assembly) to the Policy Statement Advisory Group (PSAG) via the National Office, the Policy Statement Advisory Group Chair directs that:

• the author(s) is told what major revisions or minor edits are necessary. After the author(s) has revised the statement, they may resubmit to the PSAG;

OR

• The author(s) is informed that the statement does not meet the criteria for a policy statement.

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

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

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

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

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

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

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
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CALIFORNIA

PEDIATRIC MENTAL HEALTH DIRECTOR

Job Description:
CHOC Children’s Specialists in conjunction with Children’s Hospital of Orange County (CHOC) and the University of California at Irvine (UCI), is seeking a full-time child and adolescent psychiatrist to serve as Medical Director of the Inpatient Unit. This position will provide clinical and programmatic leadership to a new state-of-the-art inpatient mental health unit for children and adolescents, clinical coverage for one of two inpatient teams, some outpatient consultation service, and supervision of child and adolescent psychiatry fellows. Successful candidate will possess a MD degree, Board certification/eligibility in child and adolescent psychiatry, experience in inpatient child/adolescent psychiatry, and eligibility for a permanent California medical license. We offer competitive salary and benefits including a 401k plan, malpractice insurance, and relocation assistance. For immediate consideration, please send CV to: CHOC Children’s Specialists Human Resources at humanresourcescsadmin@choc.org.

Company: CHOC Children’s Specialists
Job ID: 1052260
http://jobsource.aacap.org/jobs/1052260

COLORADO

CHILD ADOLESCENT PSYCHIATRY – DENVER AND ARVADA

Job Description:
We have outpatient Child/Adolescent Psychiatry job openings! Our Denver and Arvada positions are full-time. We also have per diem opportunity. This is an excellent opportunity to work with the Behavioral Health Department of nearly 30 psychiatrists in the General/Adult, Child/Adolescent, Geriatric, Inpatient, and Chemical Dependency programs. Must be BC/BE in Child/Adolescent Psychiatry. Desirable call schedule from home (extra compensation). Outpatient only, no in-patient. You will have an opportunity to work with a team of physicians who practice in a staff model with LCSWs, Psychologists and nursing support. We have a dedicated pharmacy for Behavioral Health. The advantages of working with us include state-of-the-art electronic medical records system, collegial team environment and excellent compensation and benefit package. The Colorado Permanente Medical Group (CPMG) is a physician-managed, multi-specialty group who recognizes and values our Psychiatrists as a key cornerstone in our healthcare delivery model. There are opportunities to partner with primary care on consultation for addictions. We offer a: Physician led group Focus on continuity and outcomes Primary care rich with support State of the art electronic records system Collegial team environment Salaried position, sign-on bonus available with excellent benefits (vacation, holidays off, sick leave, cash balance pension plan, 401K, full health/dental insurance, malpractice insurance, and more!) When it comes to quality health care and quality of life, CPMG provides a rich opportunity for both. Our leadership in the Colorado region is focused on creating a positive work environment where health care professionals can build a rewarding career. By supporting our physicians, we have produced an excellent record of satisfaction and retention. The Colorado region offers metropolitan living near the Rocky Mountains, plus excellent opportunities for sports and recreation, including hiking, camping, skiing, and mountain biking. It’s a great place to live and work! If you believe in getting more out of life, contact the Colorado Permanente Medical Group! Call Amy Chang at 303-344-7246, or email at amy.l.chang@kp.org. EOE/M/F/V. https://cpmg.taleo.net/careersection/ex/jobsearch.flt

Job Requirements:
Must be BC/BE in Child/Adolescent Psychiatry and see adults as well. Experience preferred, but new graduates are encouraged to apply.

Company: Multispecialty group
Job ID: 10382259
http://jobsource.aacap.org/jobs/10382259

MASSACHUSETTS

BOSTON CHILDREN’S HOSPITAL-HARVARD MEDICAL SCHOOL CHILD PSYCHIATRIST

Job Description:
We are continuing to grow! It is an exciting time for us as we respond to Boston Children’s Hospital’s call for us to continue to expand our behavioral healthcare landscape. We welcome inquiries from anyone who might be interested in joining the Department of Psychiatry. At the moment, we are especially interested in the following positions: ATTENDING PSYCHIATRIST, INPATIENT PSYCHIATRY UNIT in BOSTON, MA. This position is for individuals interested in providing assessment and collaborative treatment services for children and adolescents requiring psychiatric hospitalization on our 16-bed inpatient psychiatry service at Boston Children’s Hospital. The patients are diverse and challenging including those facing co-morbid emotional and physical disorders. ATTENDING PSYCHIATRIST, BEHAVIORAL HEALTH PROGRAM in WALTHAM, MA. This position is for individuals interested in providing assessment and collaborative treatment services in the outpatient setting. This individual will be an instrumental partner in developing a new outpatient satellite Behavioral Health Program at Boston Children’s Hospital – Waltham. The individual will work as a team with child psychologists to care for children and adolescents referred primarily from the Hospital’s primary care network of pediatricians. MEDICAL DIRECTOR, COMMUNITY BASED ACUTE TREATMENT UNIT in WALTHAM, MA. This position is for individuals interested in providing assessment and collaborative treatment services for children and adolescents requiring intensive psychiatric services on our 12-bed CBAT unit at Boston Children’s Hospital - Waltham. The patients are diverse and challenging, often in lieu of inpatient hospitalization or in the midst of transitioning out of residential care.
Job Requirements:
In all positions, we are looking for individuals with a collaborative nature that sustain and build working partnerships both within and outside Department. Candidates for these positions must be board eligible/certified in general and child psychiatry. Appointment at Harvard Medical School as Instructor, Assistant or Associate Professor will be commensurate with experience and will require ongoing teaching.

Company: Boston Children’s Hospital (881542)
JOB ID: 10342442
http://jobsource.aacap.org/jobs/10342442

SOUTH CAROLINA
EMERGENCY PSYCHIATRIST - GREENVILLE, SC

Job Description:
Greenville Health System (GHS) seeks an Emergency Psychiatrist as faculty in the Department of Emergency Medicine, Division of Emergency Psychiatry. Successful candidates should be prepared to shape the future of Emergency Psychiatry at GHS and contribute to the academic output of the department. GHS is the largest healthcare provider in South Carolina and serves as the tertiary referral center for the entire Upstate region. As an integral system component, the Department of Emergency Medicine provides care in 6 Emergency Departments and 5 urgent care centers. Our program offers: Division leadership that is dual trained in Emergency Medicine and Psychiatry; Dedicated Psychiatric Area within the ED; Team of psychiatric social workers and advanced practice providers with mental health training; Inpatient child and adult psychiatric units located on campus; Five Community Hospital Emergency Departments; Level 1 Trauma Center; Dedicated Pediatric Emergency Department within the Children’s Hospital; Accredited 3-year Emergency Medicine Residency Program and 4-year Psychiatry Residency. The campus hosts 15 residency and fellowship programs and one of the nation’s newest allopathic medical schools – University of South Carolina School of Medicine Greenville. Faculty within the newly developed Emergency Psychiatry Division within the Department of Emergency Medicine enjoy a flexible work schedule, highly competitive salary, generous benefits, and additional incentives based on clinical, operational and academic productivity. Greenville, South Carolina, is a beautiful place to live and work. It is one of the fastest growing areas in the country, and is ideally situated near beautiful mountains, beaches and lakes. We enjoy a diverse and thriving economy, excellent quality of life, and wonderful cultural and educational opportunities. *Public Service Loan Forgiveness (PSLF) Program Qualified Employer* Qualified candidates should submit a letter of interest and CV to: Kendra Hall, Sr. Physician Recruiter, kbhall@ghs.org, ph: 800-772-6987. GHS does not offer sponsorship at this time. EOE

Company: Greenville Health System (928051)
JOB ID: 10394031
http://jobsource.aacap.org/jobs/10394031

Mid-Atlantic
Prime Mid Atlantic Location - Child and Adolescent Behavioral Health

Job Description:
Summit Behavioral Health seeks a BC/BE Physician trained in Pediatric Behavioral Health or Psychiatry with Child/Adolescent experience to join their team of 4 Physicians and 3 CRNPs. Call 1-4. We offer a wide-variety of services and treatment options for anyone who is experiencing mental health and substance use challenges. We believe that the best chance of recovery is through supportive and individualized treatment. Inpatient call only, 24/7 on a rotating basis. Outpatient hours are M-Th, 8-7, Friday 8-5. The following therapies and treatments are offered for children and adults during day and evening hours: Couples Therapy Family Therapy Group Therapy Individual Therapy Medication Management Older Adult Services Play Therapy Treatment of Eating Disorders Diagnostic Evaluations Benefits Competitive salary, sign on bonus or educational loan repayment Health, life and disability insurance Retirement savings plan with employer automatic contribution and match Medical malpractice insurance and tail coverage Generous allowances for CME, Dues, and Relocation assistance For immediate confidential consideration or to learn more please contact: Sharon McCleary, Physician Recruiter, 717-709-4756 smccleary@summithealth.org. Visit www.SummitHealth.org for more information about Summit Health. Enjoy our video: https://youtu.be/hduyrqLVwY
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