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64TH ANNUAL MEETING
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**Cover Photo:** Dr. Martin crossing the Continental Divide! Like the Break the Cycle Facebook page to keep on track with him through October.
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.

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Infant Psychiatry and Integrated Care

At a recent social gathering, I mentioned in passing that I thought infant mental health was an extremely important area. Another guest at the event, perhaps fueled by a second glass of wine, launched into what I’m sure he considered a hilarious comic routine having to do with babies getting psychoanalyzed. The underlying point was that the whole concept of caring about the psychological health of very young children is ridiculous. Although I was sorely tempted, I did not rise to the provocateur’s bait and extricated myself shortly thereafter, preserving an otherwise enjoyable evening.

What I wanted to do, had it not been totally inappropriate given the setting, was to describe all that we’ve learned about infants since the 1970s, when many professionals believed, like the self-styled comedian, that babies were just a “bag of reflexes” that needed tending until they got bigger. Now we know infants and young children are incredibly complicated beings who impact the world around them and whose rapidly developing brains are exquisitely sensitive to both positive and negative experiences. One of the pioneers in this field of infant psychiatry is Charles Zeanah, MD, who I’m pleased to say will be my presidential interviewee at the upcoming meeting in Washington, DC, this October.

There have been a number of investigations on Adverse Childhood Experiences (ACEs), which compliment Dr. Zeanah’s work. The initial ACE study appeared in the late 1990s as a retrospective analysis of over 13,000 adults’ early childhood exposure to seven categories of adverse experiences (psychological, physical, or sexual abuse; violence against the mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned). The study found that ACEs were remarkably common, with more than half of the subjects reporting at least one and about a quarter reporting two or more. Adults’ health risks, ranging from psychiatric disorders and substance abuse to chronic medical diseases, were strongly related to the number of ACEs experienced in early childhood.

Subsequent research (none more dramatic than Zeanah’s studies of Romanian orphans) has shown that maternal stress during pregnancy, impaired attachment, and poor nutrition in utero and during infancy also are associated with adverse medical and psychological outcomes during adulthood. The biological mechanisms that result in ACEs leaving permanent scars are beginning to be identified. The field of epigenetics (referring to the way one’s environment and experience affect innate gene expression without altering the DNA sequence) has much to offer in this regard. For example, epigenetic factors may well explain how exposure to maternal stress in infancy leads to altered response to stress in the exposed individual later in life.

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Advances in neuroscience during the “Decade of the Brain” and subsequently also aid in elucidating the impact of ACEs. Recognition that the brain of an infant, child, or even an adolescent is far from biologically fully developed helps us appreciate its vulnerability to environmental factors. The myriad of chemicals that bathe the developing brain include stress hormones, prolonged elevations of which can permanently alter the architecture of the brain at both the anatomic and cellular level.

Together, one’s brain and genetic makeup (including epigenetic alterations) control the basic physiologic processes of the body, which in turn mediate moods, memories, the assessment of danger, the experience of pleasure, irritability, and learning. It’s an incredibly complicated and inter-related series of influences and processes, and our burgeoning knowledge has barely scratched the surface. However, the most exciting aspect of understanding the association between ACEs and adult morbidity – and the mechanisms behind the associations – is the opportunity for prevention or early intervention to disrupt the negative cycle.

The evidence for the effectiveness of such programs is accruing steadily. Placement with foster families dramatically ameliorated many of the Romanian orphans’ developmental deficits. A home-visiting nurse program directed at first time mothers during pregnancy and continuing for two years after the child’s birth has shown impressive benefits on education, health, and psychosocial variables at age 12 years. Another home visiting intervention with high-risk, pregnant American Indian adolescents made such an impact on the subjects and their young children compared to controls that it is being applied more widely by the Indian Health Service. These findings substantiate what many of us have believed for decades: prevention and very early intervention are the way to go. The potential for early mental health screening and intervention to occur in primary care settings is one of the most exciting aspects of the movement toward pediatric integrated care, the focus of my presidential initiative and a number of presentations at the upcoming AACAP Annual Meeting.

Sincerely,

Gregory K. Fritz, MD
President

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.

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GUEST COLUMN – INTEGRATED CARE

Family Based Integrated Care for Complex Pediatric Illness: The Hasbro Children’s Partial Hospital Program

Michelle Rickerby, MD

Introduction

The Hasbro Children’s Partial Hospital Program (HCPHP) is a collaboration of the Department of Pediatrics and the Department of Child Psychiatry of Hasbro Children’s Hospital, in operation since June 1998. The mission is to empower children, 6-18 years of age, and their families, to face complex pediatric illness challenges including eating disorders, chronic pediatric illness complicated by non-adherence and/or psychiatric co-morbidity, complex pain disorders, and somatoform illness such as conversion disorder. The heuristic model of family based integrated care (FBIC) was developed (1998-2016) in the context of the development of the HCPHP along with the development of a family therapy training program for Brown University child psychiatry and triple board residents. FBIC provides a framework that supports case formulation and coordinated interdisciplinary care across illnesses and levels of care. A brief description of the heuristic model and of the HCPHP will outline the application of the FBIC model to high risk patients at an intensive level of care.

The FBIC Model

There is growing evidence supporting the critical impact of the family on children’s mental health. This impact is noted in research involving epigenetics, the effects of toxic stress and parental mental illness, as well as in reviews of interventions involving family based treatment. Evidence also supports that integrating medical and behavioral health practices leads to lower health care costs, decreased readmission rates, and improved outcomes including greater functioning and quality of life.

FBIC provides a construct to address family context and allows for the integration of treatment efforts and messages across illnesses, levels of care, and providers. FBIC encourages providers to join with families around their beliefs about illness and symptoms regardless of whether they are divergent from objective medical criteria and provider opinion. Providers orient themselves around the relationships between patient and family members, related to specific illness management as well as to overall functioning. Treatment goal setting is connected to the unique needs of each patient. Goals include: supporting patients and families in having accurate and mobilizing beliefs about their illness and symptoms; and supporting relationships that allow for effective support around illness needs.

The FBIC Graph

The FBIC graph was developed as a teaching tool that highlights treating a patient in the context of a family system. While providing a visual image, it also respects the complexity and fluidity involved in family dynamics. The full range of psychological evidence-based treatment can be “mapped on” to the graph highlighting where each intervention focuses on patient and family cognitive, behavioral, affective, and relational movement. This meta-view can magnify the impact of discrete interventions by taking into account family readiness and/or barriers to treatment. Use of this construct to orient joining and treatment efforts is not just for the “evaluation” but rather an effective construct to use throughout treatment.

Benefits of the FBIC Model include:

- The FBIC model combats a sense of helplessness for providers, patients, and family in the face of a powerful illness challenges and/

continued on page 204
or painful relationship patterns. Providers understand that regardless of illness severity, they can intervene in the family system in a manner that offers relief while the patient and family lives with the illness.

- The FBIC model can allow a productive avenue to manage patients and families who struggle to incorporate a psychological line of sight into understanding illness challenges.

- A focus on symptoms/illness outside the multi-dimensional context represented by the graph can grant the illness more power over the patient and family’s life rather than less. Because the FBIC model is not symptom or illness specific, it helps mitigate the dangers inherent in symptom-focused decision-making.

- The use of the FBIC model across disciplines allows for a productive magnification of messages given to patients and families.

**The PHP Model**

**Program Mission**

The mission of HCPHP is to empower children and their families to face complex pediatric illness challenges. The goal is to support the development of accurate and mobilizing illness beliefs and to support relationships between family members and with providers that are empathic and productive. Whether diagnoses are well delineated or there exists clinical uncertainty, FBIC can be applied.

**Program Development**

HCPHP opened in 1998 with a census of 6 patients. Incremental growth over intervening years culminated in an expansion to 3 milieus serving up to 24 patients in 2015. All renovations and expansions were hospital funded based on fiscal health of the program aside from a philanthropic fund that supported physical space renovation in 2000. HCPHP reimbursement has included state and private payers from the outset with bundled rates negotiated with each payer. The proportion of patients covered by state insurance has been about 30-40% over the life of the program.

**Population Served**

Patients admitted to the HCPHP are between 6-18 years of age and have combinations of medical and psychiatric diagnoses. Additional admission criteria include:

- Medical and/or psychiatric stability to not require 24 hour hospitalization
- High risk of re-hospitalization and/or at risk of needing an inpatient level of medical or psychiatric care
- Marked functional impairment
- Patient ability to communicate in English

Criteria that may preclude admission to HCPHP include:

- Recent history of aggression
- Developmental delay of a severity that precludes engagement in the therapeutic milieu
- Inability of the family to transport patient and/or inability to participate in family based aspects of care

Common DSM5 diagnoses treated at the HCPHP include: anorexia nervosa, bulimia nervosa, ARFID, pain disorder, somatic symptom disorder, conversion disorder, major depressive disorder, OCD, generalized anxiety disorder, social phobia, and panic disorder. Common pediatric illnesses include Type I DM, asthma, inflammatory bowel disorders, irritable bowel syndrome, encopresis, eczema, celiac disease, cancer, epilepsy, refractory headache, failure to thrive, and malnutrition.

**Staffing**

The range of disciplines within HCPHP include: pediatricians, child psychiatrists, psychologists, social workers, pediatric nurses, a psychiatric nurse practitioner, a CNA, milieu therapists, certified teachers, unit secretaries, registered dieticians, and a diet technician. Patients also have access to pediatric sub specialty consultation from hospital-based providers, as well as hospital based rehab and lab/imaging services (via separate billing from bundled day rate).

**Future Directions**

The FBIC Model provides a conceptual framework for treating complex pediatric illness. The HCPHP provides an example of operationalizing this model in the treatment of high intensity illness.

**Structure of the Day**

The program is highly structured with goals of: having a daily schedule 7:45 am-3:15 pm that mimics a school day; providing educational supports/remediation; providing support for nutritional needs of patients; and providing a range of psychotherapeutic supports on individual, family and group bases. Services that are worked into the fabric of the daily structure include nursing and pediatric assessment/education sessions, individual therapy three times per week, family therapy twice per week, pediatric rehab consultations and treatment, and nutrition education sessions. For parents there are two multifamily support groups per week. The HCPHP Skill Building Curriculum is a group curriculum focused on practice with coping skills informed by DBT, CBT, and relaxation training evidence based treatments.
challenges for patients who have failed less intensive treatment or who have required extensive inpatient medical and psychiatric care without being able to transition their health gains to the home environment.

Important implications of this model and its use in the HCPHP include:

- Any painful challenge/symptom/illness is improved with an empowered set of beliefs about illness and an empathic, mobilized set of relationships, which is most effectively accomplished via a family-based treatment model with integrated messages across providers.

- By intensive work with patients and families illness beliefs and relationship patterns within families can be modified, and targeting these areas can improve treatment outcomes.

- If we are oriented to “where we are” with family relationships and illness beliefs we will have the ability to most productively join with the patient and family and support their journey towards empowerment over the illness.

- Consistent messages from health care providers and across health care providers matter, are powerful forces influencing successful treatment, and can be effectively guided by the FBIC model.

- Excellent provider collaboration is a strong force in supporting patient/family efficacy in illness management and securing quality of life.

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Dr. Michelle Rickerby is a child psychiatrist in Providence, Rhode Island, and is affiliated with multiple hospitals in the area, including Miriam Hospital and Rhode Island Hospital. She received her medical degree from University of Connecticut School of Medicine and has been in practice for more than 20 years. She is one of 45 doctors at Miriam Hospital and one of 70 at Rhode Island Hospital who specialize in Psychiatry.

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Please consider a gift in your Will, and join your colleagues and friends: 1953 Society Members

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Visit www.aacap.org/1953_Society to learn more!
I wish I had a dollar for every discussion I have had on the subject of “med checks.” Many don’t like the name and suggest alternatives like the “therapeutic med check.” That seems better until you realize that pediatric psychopharmacology is a bonafide, evidence-based treatment modality that fits my definition of being therapeutic. One would never speak of a therapeutic CBT or a therapeutic family therapy session in the same light. Similarly, I have never heard of a “psychodynamic check,” although some follow-up sessions might come close.

One can certainly argue ideally that the goal of all sessions should involve a developmentally informed biopsychosocial model and that a med check is too focused on the biological to the detriment of the psycho and social. To be fair, however, there are certainly plenty of psychosocial therapies that focus on the psycho or social to the detriment of the biological.

Are we not allowed to specialize or be a consultant? Do we ask neurosurgeons to comprehensively know the complete stories of the lives of all their patients? Does every visit for medications need to be comprehensive including the electronic note and billing for visits focused on the provision of medications? I believe that 30 minutes seems an adequate amount of time to perform what Winnicott called a “piece of work.” In most 30-minute sessions, I can ask follow-up questions that allow me to satisfy my biopsychosocial inclinations and at least do some supportive psychotherapy, which I feel is the bare minimum for a psychopharmacologically-focused session.

To highlight just what can be done in a “med check,” I have decided to dedicate some future columns by my trainees allow for 30 minutes (all-inclusive including the electronic note and billing) for visits focused on the provision of medications. I believe that 30 minutes seems an adequate amount of time to perform what Winnicott called a “piece of work.” In most 30-minute sessions, I can ask follow-up questions that allow me to satisfy my biopsychosocial inclinations and at least do some supportive psychotherapy, which I feel is the bare minimum for a psychopharmacologically-focused session.

A Med Check: Things are Horrible

Clarence is a twelve-year-old African-American male who comes monthly for his medications. He is constantly upset. He looks unhappy and acts like the cartoon character that has a constant cloud over his head. He comes from a large family of all sisters, the oldest being in college. He complains of being “outnumbered” and of his needs not being met. Money is scarce in his family. He usually is brought to and shares sessions with his cheerful maternal grandmother, who constantly humors Clarence and tries to tease him out of his grumpiness. His mother, who comes in once in a while, is a dour and strict “tough lady” who tries to lecture Clarence out of his grumpiness. Neither technique works. He is locked in combat with both.

Pre-Christmas, at his monthly medication check, Clarence bombarded his mother with his wishes for Christmas: a 4-wheeler and a game system to be exact. Mom poo-pooed everything, leaving Clarence more upset. He was buoyed somewhat by Mom saying she would consider an allowance.

At the next session with his maternal grandmother, Clarence began by saying things were horrible. When I asked why, he told me that he did not get an allowance.

“What happened?” I asked.

“She didn’t do anything.”

I then told him that it takes two people to drop such a request and asked him what he was going to do to bring the subject up again. I then mentioned the idea that he needed to negotiate with his mother.

“How much of an allowance do you want?” I asked.

“I haven’t thought about that. Nobody ever asks me what I think, so I don’t think,” he responded.

“Well, I’m asking you! How much do you want?”

“Four dollars,” he replied.

“So you have thought about it,” I commented. “How did you come to that amount?”

“But I’m not going to get it,” he said with a glare.

“You absolutely won’t if you never ask. How did you come to four dollars?”
They worked some of them to death and surrounded by fences and barbed wire. and put them in camps that were prisons of the plan, they rounded up the Jews who wanted to kill all the Jews. As part of Hitler. He was the leader of the Nazis. “Well, there was this bad man named Victor Frankel who was in a concentration camp. Do you know about that?” I asked.

“Oh, I’ve heard of that. Is that when they put numbers on their arms?” He asked.

“Yes.” I then continued. “Victor Frankel was there in a concentration camp and survived by noting that they could torture him and kill him, but that they couldn’t take his thoughts and dreams away from him. Do you get that?”

“Sort of,” he said.

“We all need dreams, especially during times when things are not going well. It may be there isn’t enough money for you to get an allowance now, but there may be in the future. You know what is the best way to make sure there’s money, which you love?”

“No,” he said attentively.

“It’s by doing well at school, going to college, and getting a good job. A salary is an allowance for working hard.”

At that point, his grandmother picked up the theme by remarking that she has a dream to go on a cruise, but that she did not have the money.

“But couldn’t you save a little money every week and afford it eventually?” I asked.

“Yes, I guess I could,” she answered with a nod. “I always wanted to fly on a plane. I saved up for that and finally flew on a plane. I was frightened and afraid to look out of the window, but I did it. It was cool.” She then turned to Clarence and said that she would love to save up and take him on a plane too. “You’ll really like it.”

“More dreams,” I responded.

“Do you know Nelson Mandela?” I asked Clarence.

“No,” he responded.

“He was from South Africa where blacks were oppressed by a system called Apartheid, which was South Africa’s version of slavery. Mandela had a dream that one day Apartheid would end. He protested and was put in jail and was treated badly, like Victor Frankel, but he never gave up on his hopes. After 27 years in jail, he became the President of South Africa. You can read about him. Do you know about Jessie Owens?”

“No” he responded again.

“He was a black man who was the fastest man in the world in the 1930’s. He won four gold medals in the 1936 Olympics in front of Hitler; remember he was the man responsible for the Holocaust? Hitler didn’t like blacks, just like he didn’t like the Jews. He said that both the Jews and the blacks were inferior to the whites, but Jessie Owens showed him that just wasn’t true. I just watched a movie about his life called ‘Race.’ You should watch it. And speaking of dreams, you know who Martin Luther King, Jr. is?”

“Yes,” he said.

“What was his most famous speech?” I asked.

“I don’t know,” said Clarence.

“It was ‘I have a dream.’ You should read it.”

I then switched to what needed to be done to ask about his medications and write his scripts. After the session, I asked the clinic manager if there were any books I could give to the children I see. She directed me to a drawer full of books. There were none on Jessie Owens or Nelson Mandela, but there was one on Jackie Robinson. I will give it to Clarence next month and will call people to see if we can get more books for kids, including books on Martin Luther King, Jr. and Nelson Mandela.
RESIDENT MEMBER TO COUNCIL

Thank You for the Mentorship

At the June 2017 AACAP Council Retreat in Rhode Island, I was initially focused on reporting the activities of our MSR (Medical Student and Residents) Committee. When I arrived, despite the busy weekend agenda (which included driving back to Boston for graduation the following morning!), I realized that this was the last meeting I would attend as current AACAP Resident Member to the Council. It was an inspiring Retreat, with presentations by some of the most preeminent child and adolescent psychiatrists in our field.

I immediately found the seat that my mentor and friend, Douglas Kramer, MD, saved for me (thank you)! It was wonderful catching up, discussing the importance of intergenerational mentorship, and how he has exemplified this for me. This conversation is just one example of the gifts from our Life Members (Owls) Mentoring program.

“...and Fidelity (related to identity formation). I believe that although the Fidelity stage is defined as lasting until late adolescence/early adulthood, it continues deep into adulthood. The impact of forming a consistent and mature personal and professional personal identity is especially critical in our field, where we care for and attempt to model and guide children, adolescents, and their families through their own developmental trajectory. The importance of personal and professional development applies whether we are discussing medication management and therapy, performing consultations, or engaging in brief, targeted, therapeutic interventions in session. In this vein, professional development itself is a dynamic, parallel process.”

During the retreat, it was exciting to hear the upcoming agenda for Andrés Martin, MD, MPH’s Break the Cycle initiative and his groundbreaking fundraising ride across America, which will conclude at AACAP’s Annual Meeting in Washington, DC, this fall. We were inspired by an update on our outstanding journal, JAACAP, from our incoming editor, Douglas Novins, MD. We reviewed organization and membership considerations, and how AACAP is structurally organized.

On a more personal note, I deeply appreciated having the opportunity to talk with our President Gregory K. Fritz, MD, as well as Tami Benton, MD, Mark Borer, MD, Gabriella Carson, MD, and President-Elect Karen Dineen Wagner, MD, PhD.

The Medical Students and Residents Committee Life Members Mentoring Event is entering into its fourth year at the upcoming AACAP Annual Meeting, with Cordelia Ross, MD, coming on as co-chair. As I reflect on this, I realize I am coming into a role where I can provide mentorship to younger trainees, and, so far, this has been the most rewarding aspect of my AACAP experience.

As I begin an additional year of fellowship in Addiction Psychiatry, I could not be more proud of the current state of our Medical Students and Residents Committee and its future emerging leaders. The Medical Students and Residents Committee and AACAP have important plans for the Annual Meeting. Looking forward to seeing everyone in DC!

Dr. Roberto is the Jerry M. Wiener Resident Member of Council: 2015-2017. He co-chairs the AACAP Committee on Medical Students and Residents. He finished his Child and Adolescent Psychiatry program at Coston Children’s Hospital, Harvard Medical School and is an Addiction Psychiatry Fellow at Yale School of Medicine. He may be reached at aaron.roberto@yale.edu.

DID YOU KNOW?

Washington, DC, is only 69 square miles.
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 gov@aacap.org.
Fifteen years ago, Massachusetts had an energetic group of young psychiatrists trained in Disaster Psychiatry. They were leaders in the field when the disasters of 9/11 and, later, Katrina struck. The group continued to work in Disaster Psychiatry but each went in a different direction. Fred Stoddard, MD, edited the book Disaster Psychiatry: Readiness, Evaluation, and Treatment, together with Anand Pandya, MD, and Craig Katz, MD. This book provides an excellent introduction to anyone interested in learning more about disaster psychiatry. Dr. Stoddard’s interest in this area includes both practical hands-on work, and the more theoretical aspect of studying what works and what does not, so as to improve the effect and validity of our work. Others, like Todd Holzman, MD, were eager to help in different parts of the world where disaster hits, like the tsunami in South India and the typhoon in the Philippines. At Harvard, there has been international work and basic work done on the development of posttraumatic stress disorder (PTSD) and resilience. However, young psychiatrists have not been following in the field of practical Disaster Psychiatry. One reason for this may be that we have never succeeded in establishing Disaster Psychiatry as part of the residency curriculum.

My work was mostly in New Jersey where I was president of both the New Jersey Council of Child and Adolescent Psychiatry (NJCCAP) and the New Jersey Psychiatric Association (NJPA), as well as a co-founder of the Disaster Preparedness Committee of NJPA. Joe Napoli, MD, took the lead and 20 psychiatrists did Red Cross Disaster Mental Health training in 1998. Several of us continued to work with the Red Cross on many disasters. When I came to Massachusetts five years ago, I joined my local Red Cross chapter where I am now Disaster Mental Health (DMH) Lead. I have worked on one national disaster as well as local house fires every year. Dr. Stoddard asked me to work with him to reach out to younger psychiatrists to spark interest and train a core group in Disaster Psychiatry. Our first meeting was at Brigham and Women’s Hospital. Since then, I have visited Tufts, Cambridge Health Alliance, Boston University, and the University of Massachusetts Worcester with a one-hour presentation, speaking to both general residents and child psychiatry fellows. Drs. Stoddard and Holzman joined me on all the Boston visits. At each program, there were some who already had disaster experience and it sparked interest in others.

On April 8, 2017, we ran a Disaster Psychiatry Course, which was attended by 60 mental health professionals, most of whom were psychiatrists. We collaborated with the Red Cross and Christine Tehaldi, RN, MS, an advanced practice psychiatric nurse from McLean Hospital who is the Volunteer State Lead for the American Red Cross of Massachusetts Disaster Mental Health Team. We covered the history of disaster response and the systems involved, especially the role of the Red Cross, Psychological First Aid, and many aspects of disaster psychiatry, such as working with children and families. Dr. Holzman inspired us with stories of his work with the Red Cross Bombers in disaster response, and Ms. Tehaldi described her experience in the field. Dr. Napoli spoke about training workers via social media, and Dr. Holzman talked about caring for the caregiver. Dr. Fricchione, MD, described some of the new neuropsychiatric research on brain function in stress and resilience, and talked about caring for the caregiver. Dr. Napoli spoke about training workers via social media, and Dr. Holzman talked about caring for the caregiver. Dr. Fricchione, MD, described some of the new neuropsychiatric research on brain function in stress and resilience, and talked about caring for the caregiver. Dr. Napoli spoke about training workers via social media, and Dr. Holzman talked about caring for the caregiver. Dr. Fricchione, MD, described some of the new neuropsychiatric research on brain function in stress and resilience, and talked about caring for the caregiver.

Going forward, we need to continue speaking at residency and child fellowship programs and mentoring those who express interest in disaster preparedness in order to develop a new cadre of disaster psychiatrists. Given the apparent increasing frequency of disasters, we hope that disaster psychiatry will be included in training programs. In addition, psychiatrists need to be included in the disaster drills in hospitals. In the meantime, our continued efforts to train young psychiatrists and child psychiatrists are vital.

Margaret E. Tompsett, MD

Dr. Tompsett was in private practice in Summit, New Jersey, for many years and relocated to Massachusetts in 2012. She is a past president of the New Jersey Council of Child and Adolescent Psychiatry and of the New Jersey Psychiatric Association. She is a recipient of the American Psychiatric Association Bruno Lima Award for her work in assisting people affected by disaster and a member of the AACAP Disaster Preparedness Task Force. She is co-chair of the Disaster Preparedness Committee of the Massachusetts Psychiatric Society. She has been actively working with the Red Cross on many local and national disasters. She may be reached at metompsett@gmail.com.
Together We Can *Break the Cycle*

Rachel Ritvo, MD

Children’s mental illnesses are real, common, and treatable. Yet today in the United States, our patients are caught in a vicious cycle of limited access to care, delayed treatment, and worsening illnesses. Andrés Martin, MD, MPH, the outgoing editor of the *Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP)*, has challenged our members to join him in raising awareness and money to 1) fund innovative 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.

Looking for a new challenge after editing JAACAP for ten years and, by his report, under the sway of a midlife crisis, Dr. Martin embraced the challenge of bicycling across the United States from Washington State to Washington, DC. As he contemplated the challenge of this cross-country ride, he realized he could use this journey to give back to AACAP, and to our patients and their families, by raising awareness of the challenges faced by children with mental illnesses. He is hopeful that he can also raise funds for AACAP’s Campaign for America’s Kids, which aims to support innovative initiatives in advocacy, education, and research that improve access to mental health treatments for all children. Dr. Martin has invited AACAP members and supporters to accompany him as he set out on August 17, 2017, on the first leg of the trip, from Seattle to Portland (days 1-3), or along the Eastern Seaboard from October 15, 2017, until his arrival in Washington, DC, on October 22, the day before AACAP’s Annual Meeting begins (days 53-60). Whether a cyclist or not, all members are encouraged to become engaged with Break the Cycle, perhaps by setting up a personal fundraising page at breakthecycle.aacap.org/donate.

As of August, 32 individuals have signed up to ride, 183 have taken the pledge in support of the ride, and over $159,000 has been raised. To learn more about the riders and their motivations, click on the riders’ names at breakthecycle.aacap.org/riders.

You do not need to get out on the road to participate in the *Break the Cycle* campaign. Why not plan an event with your local council? Nine councils have already signed up to host events. The New Jersey Council of Child and Adolescent Psychiatrists (NJCCAP) took the lead with a spin cycling party in May that raised over $4,200. Excited by the presentation on *Break the Cycle* at AACAP’s 63rd Annual Meeting, Anne Frederickson, MD, of NJCCAP said they decided to plan an event at the local level that “would bring together our members and other mental health providers.” The bulk of the money raised came from participants, but they also had in-kind donations from the local grocery stores, a bagel shop, and a printer who made them water bottles. The event raised awareness of child and adolescent mental health needs and the role of child and adolescent psychiatry in their community. Anne and Andrés both remarked on how helpful AACAP staff has been in putting this campaign together and encourage leaders of Regional Organizations of Child and Adolescent Psychiatry to call AACAP’s central office at 202.966.7300, ext. 140, for help in planning an event.

We also encourage you to visit breakthecycle.aacap.org for more information. You can make a donation, take the pledge, sign up to ride, and find tools to help promote the event on social media.

AACAP has long depended on charitable donations to fund diverse initiatives such as travel grants for medical students and early career investigator awards. Many members were concerned that too much of the funding came from pharmaceutical companies. Between 2008 and 2016, Pharma donations to AACAP declined by 73%, a decrease of $737,000. It is very important that members pull together to find new sources of funding to continue and grow these programs. *Break the Cycle* is an important start! By stimulating our own members’ enthusiasm and by raising awareness in our communities, together we can indeed break the cycle of stigma, workforce shortages, and limited access to care for our patients and their families.

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

Henry Kronengold
Routledge 2016
Paperback: 134 pages – $34.95

In *Stories from Child & Adolescent Psychotherapy*, Henry Kronengold presents six case studies from his work as a child and adolescent psychotherapist. Kronengold’s rich language and gift for storytelling brings life to each case, capturing the playful, challenging, and rewarding nature of psychotherapy with young patients. Humor and heartbreak abound as the rich emotional experience of therapy is captured. While technique and guiding theories are considered, the stories explore the importance of the therapeutic relationship and the *curious space* where the therapist and patient meet and work together. The value of psychotherapy in the management of children and adolescents is celebrated and highlighted in this book. As Kronengold notes, “the idea of this book is not so much to answer the question of what we are doing, as much as it is to allow this question to simmer, and stimulate ideas about working with children and adolescents.”
Douglas K. Novins, MD, has had an extraordinary career as a researcher, teacher, clinician, administrator, and editor par excellence. He is a marathon runner, cyclist, artist/photographer, and married to his college sweetheart with whom he has two daughters, both in college. His awe-inspiring career in child and adolescent psychiatry happened because—with the support of mentors he sought out and used well—he seized on chance opportunities and pursued them diligently and enthusiastically. This article briefly traces Doug’s career and preliminary plans for the future of the Journal of the Academy of Child and Adolescent Psychiatry (JAACAP).

Doug’s parents, especially his pediatrician father who re-trained as a psychiatrist in New York City when Doug was very young, strongly influenced his becoming a physician. “Medicine was part of the culture in my family.” But he also loved to draw. As a Columbia University undergraduate, he felt torn between architecture and medicine. Both parents raised concerns about a career as an architect and encouraged him towards medicine. His father loved being a psychiatrist. When Doug was accepted to the College of Physicians and Surgeons of Columbia University, his younger sister said “thanks for becoming a doctor so now I don’t have to.”

Doug did his general psychiatry training at New York University (NYU) Bellevue when Magda Campbell, MD, was chief of child psychiatry. All psychiatry residents completed four months of inpatient child and adolescent psychiatry; two of Doug’s long-term psychotherapy patients were a child and an adolescent he treated into the fourth year of his residency. He loved having to think simultaneously as a doctor and as a child (getting on the floor and drawing with his patients). He was a chief resident in general psychiatry because of his strong interests in health systems and administration, but his clinical experiences led him to child and adolescent psychiatry.

A researcher from the Dunedin Multidisciplinary Health and Development Study presented at NYU Grand Rounds and showed beautiful photographs of New Zealand. The speaker mentioned that they were always looking for collaborators from other countries. Doug’s wife, Andrea, was finishing her clerkship for a judge in NYC. They had already decided to move out to the West Coast where they had family, but when Doug brought up the idea of a year in New Zealand, Andrea was enthusiastic. During that year abroad, Doug worked at a tertiary mental health facility serving many Maori families and people from other parts of the South Pacific. He tried to learn about how his patients understood their mental health challenges and how to best address them in a culturally sensitive way.

Upon returning to the United States a year later, Doug began his child and adolescent psychiatry training at the University of Colorado Health Sciences Center in Denver, Colorado, under the late Bob Harmon, MD, a major figure in child and adolescent psychiatry and his first mentor in the field.

Shortly after Doug started training, Don Bechtold, MD, his training director, introduced him to Spero Manson, PhD, a cultural anthropologist and member of the Pembina Chippewa Tribe, who directed the University’s American Indian health research program. This became another major career turning point for him. Spero had just started the first longitudinal study of American Indian high school students in the western United States and was collecting survey data, which needed to be analyzed. Doug seized this opportunity, had Spero become his mentor during his elective time, and analyzed the data while doing his child and adolescent psychiatry training and serving as a chief resident.

Spero encouraged Doug to establish his career. So, during the second year of his child and adolescent psychiatry training, he applied for pilot research funding from AACAP and the American Psychiatric Association, and submitted a K-Award application to the National Institute of Mental Health (NIMH). Dr. Novins was awarded pilot research funding from AACAP, which allowed him to study mental health issues among American Indian adolescents being treated for substance abuse at a tribally operated residential program in Oklahoma.

Shortly after graduation, he started the research and enrolled in the University of Colorado’s T32 postdoctoral program in developmental psychobiology. Six months later, he received his K-Award and joined the department as an assistant professor. The K-Award funding allowed Doug to take formal coursework in epidemiology, biostatistics, and research methodology. Leading services researchers who worked with diverse communities mentored him, including Clifford Attkisson, PhD, Lonnie Snowden, PhD, Bernice Pescosolido, PhD, and Margerita Alegria, PhD. In Colorado, Spero, as well as Janette... continued on page 214
Beals, PhD, and Christina Mitchell, MD, were mentors who helped him hone his data analysis and writing skills. With the help of an AACAP Presidential Scholar Award, Spero and Bob, connected Doug with William Sack, MD—division director of child psychiatry at Oregon Health Science and University School of Medicine—who worked with American Indians. This strong group of mentors were invaluable in helping Doug with research methodology, data analysis, grant writing, and publishing papers.

Since Doug’s first two primary mentors, Bob and Spero, were extremely busy, he would prepare an agenda and send it to them in advance listing the three-to-five items he hoped to discuss. Afterwards, he would report back on his progress. Now that he has mentees of his own, he helps them develop a similar structured approach to using mentors.

How did Doug get involved in writing and editing the work of others? The American Indian Research Center publishes its own MEDLINE-indexed journal, American Indian and Alaska Native Mental Health Research, edited by Spero. He asked Doug to guest edit an issue that reported the results of mental health needs assessments in four urban American Indian communities (published in 1999). Doug enjoyed helping the authors prepare their papers and wrote his first editorial. He performed a similar role for another set of papers for that journal, reporting the results of the first cycle of the Substance Abuse and Mental Health Services Administration (SAMSHA) Circles of Care initiative, which supports American Indian and Alaska Native communities in improving mental health services for children and families (published in 2004). Recently, Doug even started a journal from scratch, The Colorado Journal of Psychiatry and Psychology, hoping to give junior faculty an opportunity to participate as authors, peer reviewers, and editors.

During Mina K. Dulcan, MD’s editorship of JAACAP (1998-2007), Bob (one of Mina’s deputy editors) recommended Doug as a reviewer. The quality of his reviews earned him a spot as a reviewer on the JAACAP Editorial Board in 2004. Shortly after he completed his two three-year terms on the Editorial Board, Andrés Martín, MD, MPH, who became editor-in-chief of JAACAP in 2008, appointed Doug as a deputy editor with primary responsibility for JAACAP’s epidemiology and services research portfolio.

In 2015, as Andrés term neared its end (2008-2017), AACAP convened an Ad Hoc Committee on Editorship and Publications to conduct the search for the next editor-in-chief. Several colleagues encouraged Doug to apply. His career was already rich and varied. By 2016, Doug had been the Cannon and Lyndia Harvey Chair in Child and Adolescent Psychiatry for three years; chair of the Pediatric Mental Health Institute at Children’s Hospital Colorado; and professor, vice chair, and director in the Division of Child and Adolescent Psychiatry at the University of Colorado School of Medicine’s Department of Psychiatry. He was also continuing his work as professor of Community and Behavioral Health at the Centers for American Indian and Alaska Native Health in the Colorado School of Public Health. Under Doug’s leadership, the Pediatric Mental Health Institute had grown to 63 faculty with expanded research, training, and clinical activities. He really enjoyed editing and seeing papers through the review and publication process, but wondered whether he could add the chief editorship to an already very busy schedule. Before applying, he discussed his interest and the potential impact on his current work, with colleagues in Colorado.

When I asked what he would drop from this busy schedule, he felt it had already become challenging for him to serve as a principal investigator on National Institutes of Health grants and as JAACAP’s editor-elect. He would need to let go of some part of his career. Although he is handing off day-to-day responsibility for the operation of the Pediatric Mental Health Institute to an outstanding leadership team, Doug intends to continue as a co-investigator and mentor.

JAACAP’s editor-elect transitions into the job during the preceding editor’s final year. When Doug was asked what he might want to change when he becomes editor-in-chief in January 2018, he said that JAACAP is already wonderful, with an incredible range of papers that gives readers an entree into the major research advances relevant to our field. He wants to continue JAACAP’s tradition of publishing a thoughtful balance of basic, translational, clinical, and services research. And he wants to continue to make JAACAP engaging and accessible, both to scientists and the entire AACAP membership.

Doug believes the biggest challenge to JAACAP is that because research has become very specialized and technical, it has become more difficult for a clinician, or even a researcher in another branch of research, to understand why a particular study was done, how it was done, and what the reader should take away from it. Doug plans to use editorials and clinical guidance to make the research articles more accessible, and to make the table of contents a place where readers can get a detailed overview of a given issue. He will work to ensure that every issue of JAACAP includes content that draws from, and is specifically relevant to, clinical practice.

When I spoke with Doug, he told me he was working closely with his associate editor-elect, Robert R. Althoff, MD, PhD, to plan for 2018 and beyond, and collaborating with Andrés to invite a new group of AACAP members to join the JAACAP Editorial Board. Given Doug’s professional and editorial track record, JAACAP is in good hands.

Check out JAACAP’s updated Guide for Authors for a preview of what to expect in 2018. Pre-submission inquiries are recommended and can be made by emailing support@jaacap.org.

AACAP members are encouraged to reach out with any questions and comments. Your feedback is always welcome at editor@jaacap.org.

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 Their Own Words: The Pressures of an American High School

Dr. Hartselle: While giving a keynote address to the Department of Education and school-based mental health clinicians in California, I spoke with Veda Lelchook, a high school junior volunteering at the event. She has a strong interest in teen mental health, especially as it relates to academic pressure. Together, we discussed writing a piece on this issue from the student perspective to inform psychiatrists more about the pressures teens are currently facing. Impressively, Veda independently created a survey for students on which to base her article and then sent me the results and her written interpretation. She reviewed the survey with the school mental health staff and administration prior to distribution and after survey was returned by participants. An anonymous link to the questionnaire was sent to all of the teachers, who in turn sent it to their students, and the results were collected on a de-identified survey link. No questions were pointed at self-harm or suicidality. Students could voluntarily opt-in to respond to the questionnaire via the anonymous link. The survey asked students to rate their stress levels in various situations and also to discuss their self-perception of worry, sadness, and whether or not they have sought help for the stress. The questionnaire also touched on barriers for not seeking help. Though it was informal, this student-initiated survey reflects real responses in a typical, large public high school in California and speaks volumes about where we, as psychiatrists, need to invest more in research and resources.

Veda: I attend a large, public high school in California and the pressure to obtain acceptance to an elite university is high for many students. It seems that the majority of university bound students over-perform and are over-scheduled. Personally, it feels like it has been years of being constantly busy. My calendar is steadily filled with college-oriented activities as the pressure rose to academically perform, with the goal to attend a top university. As a junior, I often feel that there are not enough hours in the day to stay ahead of Advanced Placement (AP) courses, standardized tests, and extracurricular activities, so I sacrifice sleep. The constant threat of a new pressure mounting on the horizon makes it difficult to celebrate successes and enjoy the freedom of being young.

In hopes of gaining insight into whether or not others are feeling the same pressures, I conducted an informal survey of 507 high school students in December of 2016 with the approval of my high school administration and the counseling services. I spent quite a bit of time deciding what I wanted to learn from the questionnaire, eventually settling on how much stress is impacting students’ life, generally what students feel may cause that stress, and what might be done to help. I learned that these issues affect the stress level of nearly all students surveyed, and that the vast majority of them are not seeking help.

This informal survey revealed that an alarming 73% of the students polled have experienced symptoms of stress within the past 12 months, with the most commonly cited source of stress being school work. Two-thirds of respondents rated the stress as significant.

Post-survey, a current junior explained, “The workload is pretty heavy. It is not uncommon to have three-to-four hours of homework a night.”

Other notable stressors cited were pressure to get into a top university and how to manage time outside of school hours. Another current junior explained, “If my GPA isn’t well above a 4.0, I don’t have a chance. I struggle to manage so many different things just to have a chance that I usually have to stay up very late at night to get it all done. I constantly feel behind and there is no time to relax.” Student perception of family pressure was also prevalent, with about half of the students seeing this as an issue. This junior discussed the impact of family expectations. “I don’t want to disappoint them. I work so hard, but things are a lot different now than when they were in high school and they just don’t get it.” Time is a precious commodity for the students and balancing that can feel like an added stressor. A student explains, “Time management is really tough, especially when most of my school work is just busy work. If teachers assigned more meaningful assignments, I think I would learn more in less time and that would definitely relieve some stress.”

Dr. Hartselle: According to UpToDate®, the 12-month prevalence of anxiety disorders in adolescents has been noted to be approximately 25% (Achenbach et al. 1995; Merikangas et al. 2010), but this information is based on older studies. With social media and increasing application rates to colleges, it is possible that as a society, we are seeing more mental health issues in high school students. UpToDate® is an evidence-based, physician-authored clinical decision support resource which clinicians trust to make the right point-of-care.

Veda: This high school has recognized student pressure and stress, and was already working to implement programs continued on page 216
addressing these issues when I began the survey. In speaking with the administration and guidance post-return of the survey, they acknowledged that a major culture change in decreasing stigma surrounding academic-related stress may be required. Already programs in place include: a daily intervention period, tutorial courses for struggling students, and recommended limits on the number of AP classes a student can take yearly. Mindfulness training has also been made available to students, teachers and parents. Teachers have been practicing meditation and mindfulness activities in the classroom to help ease student stress, and the school has funded programs to build resilience and diminish stigma surrounding mental health issues. In addition, the College and Career Center has established new programs for families navigating the post-high school decision process. The career counselor shared this, “The myth that students need to overachieve in order to gain acceptance into a ‘good’ university is one that this school works hard to debunk early on.” Finally, two school therapists were hired to address topics such as low mood, anxious thoughts, trauma, grief, and relationship difficulties. The counseling program was cited as being incredibly helpful for those participating. In general, the students voiced appreciation for the interventions in place but also overwhelmingly reported that more can be done. In spite of the movement toward increased interventions, this informal poll indicates that a major culture change may be needed to protect student mental health.

**Dr. Hartselle and Veda:** Schools, families, and entire communities need to focus their attention on this effort to promote a balance in teen emotional and academic achievement needs. By setting more reasonable expectations, providing student support and, perhaps, teaching coping skills to embrace setbacks, teens could learn to set reasonable goals that balance their emotional and academic achievement needs.

**Veda:** As students, we also need to take responsibility for what is occurring and gain confidence in streamlining our own activities or in cutting AP classes to balance emotional health with long term goals. Without concentrated efforts from students, teachers, administrators, parents, and community members, empowering students to feel they can put their health first will be challenging.

My hope is that this informal survey can help to provide a window into an American public high school and its academic track students. Clearly, more research is required to understand the impact of what has been touched upon here, but by highlighting the issues, I hope we can accelerate the movement toward improving student mental health.

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**References**


Dr. Hartselle is clinical assistant professor in the Department of Psychiatry at Brown University. She may be reached at stephaniehartsellemd@gmail.com.
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.
Psychiatry and Senseless Violence: Attempting a Psychological Autopsy

There can be no excuse for the heinous crime committed a little over a year ago (June 2016) by a deranged person at the Pulse Nightclub in Orlando, Florida. The perpetrator shot and killed 49 innocent individuals. Many more were left wounded and traumatized. However, as psychiatrists, we should try to look beyond the violence and understand the working of a distorted mind.

I am not attempting to examine the role of fanatical groups who may have influenced the perpetrator. My sole objective, as a psychiatrist, is to understand why he acted the way he did. Was he mentally ill and possibly experiencing a first-break or a major psychiatric disorder, or was he a person with criminal intent and behaviors, or did he meet criteria for both? Was he driven by a personal destructive ideology, i.e., a perverted interpretation of religious, national, or political beliefs?

Although, the perpetrator, Omar Mateen (OM), can no longer be evaluated for a psychiatric disorder, a psychological autopsy is possible using publicly available information. Based on these records, OM was a 29-year-male of Afghan descent, who was employed as a security guard. He had poor anger-control and a long-standing history of fighting in school, resulting in multiple expulsions. He may have had a learning disability and required one-to-one instruction. He was bullied for being overweight and for not eating pork. However, despite reports of lack of discipline going back to the third grade, he did not receive any psychological help.

These behaviors continued during his high school years, where he was involved in frequent fights and expulsions from high school for a total of approximately 48 days, as well as expulsions from the police academy due to his threatening behaviors. Media reports suggest that this last expulsion from the police academy resulted in the failure to achieve his life-long ambition to join the police force. Perhaps, this was one of several missed opportunities to get help!

He was married twice. According to his second wife, he had homosexual tendencies. He had expressed fascination with firearms, especially around incidents involving mass violence and with other violent groups. There was also a history of domestic violence. For an unspecified time prior to the incident, he was also probably using steroids.

OM’s interest in violent themes appears to have increased as he reached adolescence. For instance, around the time of the 9/11 attack on the Twin Towers, when he was approximately 14 years old, he was overheard saying that he knew how to use an AK-47 rifle. Around the time of the Virginia Tech shooting, he openly expressed interest in obtaining a firearm. Following the Boston Marathon shooting, he claimed to know the Tsarnaev brothers, although no links were found. In the weeks leading to the shootings in Orlando, OM’s behavior became progressively more erratic. He was described as “scary,” “angry” and “a ticking time bomb.” He seemed to have become grandiose and impulsive. He had started buying expensive gifts and even signed away his share of the family house to his sister for $10. Were these signs of a major psychiatric break down?

We will never know conclusively whether OM was indeed mentally ill, or what was his psychiatric diagnosis; however, it is clear that OM was a highly disturbed individual, one who could have benefitted from mental health intervention and care over the years. Although it is impossible to predict violent crime, the scale of the tragedy on that fateful night in June 2016 in Orlando calls for examining all aspects of the terrorist’s behavior that might help identify similar individuals and provide timely intervention.

Extremism and mental illness are not mutually exclusive conditions.

Dr. Ghaziuddin is an Associate Professor of Child and Adolescent Psychiatry at the University of Michigan, Ann Arbor. She serves as AACAP News Columns section editor. She may be reached at neerag@med.umich.edu.

DID YOU KNOW?

Three alligators have lived in the White House (John Quincy Adams and Herbert Hoover owned them).

Neera Ghaziuddin, MD
Haunted Souls: Tales of Immigrant Children Being Torn from Their Parents in America

Shawn S. Sidhu, MD, Orlando Ortiz, MD, and Amitha Prasad, MD

America has been a nation of immigrants since its very inception. Thousands upon thousands who have sought our shores fled one form of persecution or another, and underwent perilous journeys in which they suffered tragic losses, all for the promise of living a free and honest life. One of our core identities as a people has long been to serve as a beacon light on the rocky shores of humanity’s greatest storms.

Despite the continued presence of international humanitarian crises, including the worst displacement of refugees since World War II in the current Syrian conflict, recent national policies have turned the lights of the proverbial beacon off to the outside world. Furthermore, there have been active efforts to deport those who have already reached our homeland, many of whom have been living an honest life in this nation for decades with their families. This unfortunately has resulted in the traumatic separation of children from their parents. Parental separation is one of the most traumatic childhood experiences possible. It can permanently scar children emotionally, significantly alter their identity formation and ability to form trusting attachment relationships, and is a risk factor for a number of other psychosocial stressors and adverse outcomes. Moreover, the jarring and forceful nature in which immigrant parents have recently been arrested by the United States Immigration and Customs Enforcement (ICE) officers, often times very publicly and in the loving presence of their families, places children at even greater risk. Critics of these new policies allege that rather than targeting violent criminals and drug dealers, the recent executive orders have served to tear apart hundreds of honest, hard-working families that have become contributing members of their communities, have in many cases paid taxes and even created jobs that employ other Americans, and have very low-level immigration crimes. This article sheds light on the issue by giving a name and a face to those without a voice in our current geopolitical landscape.

Guadalupe García de Rayos (Phoenix, Arizona) is a mother of two who arrived in the United States when she was 14-years-old and had been living in Arizona over two decades. She had been complying with routine visits to the local ICE office for several years during which ICE was completely aware of her living in the United States. She had been working at a local amusement park and was described by many as a “threat to nobody.” Following the policy changes of the new administration, she again voluntarily presented for a routine check-in with ICE, only this time to be arrested, detained and deported to Mexico. Her only crime had been the use of an illegitimate ID card. Her remaining daughter in the United States was 14-years-old and had been living in the United States for over a decade. She was 14-years-old and had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade. She had been living in the United States for over a decade.

Blanca Borrego (Houston, Texas) is a mother of three who was living in the United States for over a decade. She presented with her 8-year-old daughter for a routine gynecology appointment, and had private health insurance through her husband’s job. She was escorted back to an examination room where a deputy handcuffed her and took her to the county jail. Borrego has a 22-year-old college graduate studying to become a physical therapist and a 19-year-old currently in college and simultaneously working. Her 22-year-old daughter sobbed as she recounted, “I know she’s scared. I can hear it in her voice. We’re not bad people. We don’t hurt anybody. My siblings and I have done everything right, and we just want to help my mom so she can be with us and not worry about getting detained anymore” (Hennessy-Fiske 2017). The family remains most concerned about the 8-year-old who remains considerably distressed. It is reported that the gynecology clinic staff had tipped off local law enforcement, which some are calling “a violation of the doctor-patient relationship of trust.”

Romulo Avelica-Gonzalez (Los Angeles, California), a father of four who had been living in the United States for more than 25 years, was arrested while dropping his 13-year-old daughter off to school for an 8 year-old Driving under the Influence (DUI) charge and a failure to obey a removal order. He was removed in the presence of his wife and daughter. A heartbreaking CNN video captures his daughter sobbing as

continued on page 220
Daniela Vargas (Jackson, Mississippi) is a 22-year-old transitional age female, who was brought to the United States from Argentina at age 7. She has qualified for the Deferred Action for Childhood Arrivals (DACA) program since age 9 and was in court seeking a protection order for severe domestic violence on May 9, 2017. She had filed three reports of alleged abuse, including most recently being attacked with a knife by her boyfriend. Following a protection order granted by the judge, and against the wishes of the judge herself, ICE officers dressed in plain clothes apprehended and arrested Ms. Gonzales-Torres in the courtroom. It is speculated that the boyfriend who had reportedly abused her was the one who had tipped ICE off about her legal status. In response, ACLU Texas Executive Director, Terri Burke, stated, “This wrongheaded enforcement action sends the message that if a victim is undocumented, future domestic violence may go unpunished. Home invasions may go unpunished. Rape may go unpunished. Human trafficking may go unpunished. If ICE stands by this arrest, it will make every city in America…less safe” (CBS/Associated Press 2017).

It is very troubling to know that there is a sizeable segment of the child and adolescent population in this country, potentially millions of youth, who are suffering emotionally and feel they cannot safely reach out for treatment. Child and adolescent psychiatrists understand how critical prevention, early identification, and early treatment are to the long-term health and well-being of youth. Not only is helping those in distress central to our Hippocratic oath, but doing so also provides a considerable reduction in downstream costs to the entire system and improves the overall quality of life in our society.

Child and adolescent psychiatrists will have to think very carefully about how to reach such individuals and their families. This will have to include significant outreach to minority communities, schools, juvenile justice settings, the foster care system, and local grass roots organizations. It will also mean collaborating with AACAP Staff, AACAP Assembly, AACAP Governmental Affairs and Advocacy Committee, Regional Organizations of Child and Adolescent Psychiatrists, and also groups outside of AACAP such as Physicians for Human Rights, Health Right International, and other professional groups.

The problem of identifying and providing high quality care to vulnerable immigrant youth and their families is not likely one that will be completely resolved within our lifetime. However, if we work hard, work smart, and work together, we can make a tremendous difference in the lives of those families that we do reach. We must harness our passion, empathy, and basic humanity as a tool to cut through apathy and push past systemic barriers.

Many of us end our days by tucking our little ones into bed at night with a warm embrace. The chilling reality is that millions of parents in this country do so not knowing whether or not this embrace will be their last. It was Martin Luther King, Jr., who stated “The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy.”

It is time for us to take a stand.

References
Dr. Sidhu is an associate training director in Rural and Community Training General Psychiatry Residency Program, an assistant psychiatry clerkship director at the University of New Mexico School of Medicine, and an assistant professor in the Department of Psychiatry, Division of Child and Adolescent Psychiatry. He may be reached at shawnsidhu@gmail.com.

Dr. Ortiz is a PGY-3 general psychiatry resident at the University of New Mexico. He graduated from Baylor College of Medicine in Houston, Texas, and plans to complete a fellowship in child and adolescent psychiatry. His interests include rural and public psychiatry, adolescent substance use disorders, and first break/prodromal psychosis in youth.

Dr. Prasad is a second-year Child and Adolescent Psychiatry Fellow at the University of New Mexico. She is deeply passionate about advocacy issues and championing the needs of underserved patients with decreased access to care. Her career interests are women’s and infants’ mental health and adolescent substance use disorders.

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 uro@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

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

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**DID YOU KNOW?**

In Washington, DC, there is one lawyer for every 19 residents.
Join Us at AACAP’s 64th Annual Meeting!

On behalf of the entire Program Committee and AACAP Staff, we’re looking forward to seeing all of you at AACAP’s 64th Annual Meeting, October 23-28, at the Washington Marriott Wardman Park and the Omni Shoreham Hotel in Washington, DC!

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

As you’ve come to expect, we will continue to offer:

- The AACAP App! The App not only allows you to fully navigate the meeting without paper (including electronic session evaluations), but gives you access to other AACAP information (like AACAP’s Twitter feed and a member directory) as well.
- Wellness Activities: make sure to take advantage of the daily yoga and meditation classes, as well as exercise in and around DC.
- Complimentary wireless internet throughout the meeting space and hotel rooms at the Marriott and Omni. Please note, if staying the Omni, you’ll need to be a registered Omni loyalty program member to take advantage of the complimentary internet in your room.

NEW this year, we’re offering:

- A Special Symposium: Not Fake News: Gun Violence is A Serious Public Health Problem, and bringing together researchers on this topic for an in-depth look at the current status of this public health crisis.
- Extended Workshops, which are all-day Workshops providing additional time and opportunity to master evidence-based therapeutic interventions beyond what is possible in the standard 3-hour Workshop. At its conclusion, participants should have gained sufficient expertise to implement newly learned treatment approaches or interventions into their clinical practices.

We are also pleased to welcome your families to our nation’s capital! Please view the Family-Friendly Activities page on the meeting website for information on fun DC activities for children and adults alike.

With important ongoing changes in the field such as integrated care, wellness, excessive use of electronics, gun violence, the effects of “13 Reasons Why”, new challenges with children of illegal immigrants and LGBT communities, and updated research in complementary medicine and psychopharmacology, mental healthcare professionals can’t afford to miss this Annual Meeting!

Visit www.aacap.org/AnnualMeeting/2017 for more information.

See you in DC,

Boris Birmaher, MD
James J. McGough, MD
Focus On...

AACAP’s 64th Annual Meeting takes place in Washington, DC, on October 23-28, 2017. There are a wide range of topics presented at the Annual Meeting. It is an opportunity to learn new information relevant to child and adolescent psychiatrists and to obtain continuing medical education credit. The format of the meeting ranges from small group discussions to widely attended institutes. Clinical applications, basic science, translational research, and ethical issues are among the topics discussed. Wellness experiences will be available for attendees.

Listed below are examples of some of the presentations for this year’s meeting. The Annual Meeting is a wonderful time to interact with colleagues and friends. Please join us in Washington, DC!

Karen Dineen Wagner, MD, PhD, AACAP President-Elect

Institute 1: Advanced Psychopharmacology Update: Balancing Benefits and Risks
Tuesday, October 24, 8:00 am–5:00 pm (ticket)

Institute 2: Research Institute: This is Your Brain on Child Psychiatry. Any Questions? A Practical Update on the Impact of Neuroimaging Findings in Child Psychiatry
Tuesday, October 24, 8:00 am–5:00 pm (ticket)
Supported by the Research Initiative and sponsored by the Research Committee

Clinical Perspectives 2: Impact on Youth by Marijuana’s Changing Legal Status and Access: Implications for Clinicians
Tuesday, October 24, 9:00 am–12:00 pm (open)
Sponsored by AACAP’s Substance Abuse and Addiction Committee, Health Promotion and Prevention Committee, Psychopharmacology Committee, and Adolescent Psychiatry Committee

Clinical Perspectives 7: What Primary Care Providers Really Want: Four Models of Collaboration in Early Childhood Mental Health Care
Tuesday, October 24, 9:00 am–12:00 pm (open)

Symposium 2: Hidden Risk Factors for Adolescent Substance Use Disorders: Caffeine Use, Sleep Disturbances, and Their Interplay
Tuesday, October 24, 9:00 am–12:00 pm (open)

Clinical Perspectives 19: Identifying, Preventing, and Treating Suicidal Youth
Wednesday, October 25, 10:00 am–1:00 pm (open)
Sponsored by AACAP’s Physically Ill Child Committee

Workshop 8: The Collaborative Care Model for Integrated Mental Health Practice in the Pediatric Primary Care Setting: Key Skills and Approaches for Child and Adolescent Psychiatrists
Wednesday, October 25, 3:00 pm–6:00 pm (ticket)
Sponsored by AACAP’s Healthcare and Economics Committee

Clinical Case Conference 9: Ethics and Child and Adolescent Psychiatry Training: The “Hidden Curriculum”
Thursday, October 26, 8:30 am–11:30 am (open)
Sponsored by AACAP’s Committee on Medical Students and Residents, Ethics Committee, and Training and Education Committee

Symposium 12: When Depression Strikes in Pediatric Bipolar Disorder: From Recognition to Treatment
Thursday, October 26, 8:30 am–11:30 am (open)
Sponsored by AACAP’s Psychopharmacology Committee

Clinical Perspectives 37: Clinical and Research Insights Into the Assessment and Treatment of Anxiety and Obsessive-Compulsive Disorder in Youth With Autism Spectrum Disorder
Thursday, October 26, 8:30 am–11:30 am (open)

Member Services Forum 9: Containing Contagion: Perspectives on 13 Reasons Why
Thursday, October 26, 2:00 pm–5:00 pm (open to AACAP Members)
Sponsored by AACAP’s Training and Education Committee

Workshop 22: Becoming Mindful: Integrating Mindfulness Into Your Psychiatric Practice
Friday, October 27, 8:30 am–11:30 am (ticket)
Sponsored by AACAP’s Complimentary and Integrative Medicine Committee

Extended Workshop 3: Introduction to Motivational Interviewing: Skill-Building Fundamentals
Friday, October 27, 8:30 am–4:30 pm (ticket)
Sponsored by AACAP’s Committee on Medical Students and Residents and Substance Abuse and Addiction Committee

Member Services Forum 21: Resiliency in Residency and Beyond: Promoting Wellness in Yourself and Your Workplace
Saturday, October 28, 8:30 am–11:30 am (open to AACAP Members)
Sponsored by AACAP’s Committee on Medical Students and Residents, and Training and Education Committee
Annual Meeting Plenaries

Don’t miss these plenary programs by world-renowned speakers in child and adolescent psychiatry during your time in Washington, DC!

**KARL MENNINGER, MD, PLENARY**

**Depression Awareness and Screening in Youth**

Wednesday, October 25
8:00 am–9:45 am (open)
Chair: Gregory K. Fritz, MD, AACAP President, presiding
Speaker: Karen Dineen Wagner, MD, PhD, AACAP President-Elect

Karen Dineen Wagner, MD, PhD, is Professor and Chair of the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch in Galveston. Dr. Wagner received her medical degree from the State University of New York at Stony Brook and her doctorate in clinical psychology from Temple University in Philadelphia. She completed her residency in psychiatry with Harvard Medical School at Beth Israel Hospital and completed a fellowship in child and adolescent psychiatry with Harvard Medical School at McLean Hospital.

Dr. Wagner is an internationally recognized expert in the pharmacological treatment of childhood mood disorders. Her work has contributed to the development of evidence-based treatments for children and adolescents with major depression and bipolar disorder.

Dr. Wagner is the recipient of numerous honors, including an Honorary Doctorate from State University of New York; Distinguished Alumnus, State University of New York School of Medicine at Stony Brook; Psychiatric Excellence Award from Texas Society of Psychiatric Physicians; the Klerman Senior Investigator Award from Depression and Bipolar Support Alliance; the Blanche F. Ittleson Award for Research in Child and Adolescent Psychiatry from the American Psychiatric Association; the Colvin Award for Outstanding Achievement in Mood Disorders from the Brain and Behavior Research Foundation; the Mood Disorders Research Award from the American College of Psychiatrists; and the Edward A. Strecker Award from the University of Pennsylvania.

Dr. Wagner has served in leadership positions in professional organizations and has been a member of the National Advisory Mental Health Council of the National Institutes of Health. She is editor of the *Journal of Clinical Psychiatry’s* Child and Adolescent Section. Dr. Wagner is Past-President of the American Association of Directors of Child and Adolescent Psychiatry and President-Elect of the American Academy of Child and Adolescent Psychiatry.

In her inaugural address, Dr. Wagner presents her Presidential Initiative, which focuses on increasing awareness of and screening for depression in children and adolescents. Early identification of depression is critical to reduce the likelihood of social, family, and academic impairments as well as suicidality associated with this disorder.

**The Karl Menninger, MD, Plenary is supported by Ronald K. Filippi, MD, in honor of his mentor, Karl Menninger, MD.**

**NOSHPITZ CLINE HISTORY LECTURE**

**How Have Longitudinal Study Findings Changed Our Thinking About Families and Children Over the Last 50 Years?**

Wednesday, October 25
1:15 pm–2:45 pm (open)
Chair: David W. Cline, MD
Speaker: Michael Rutter, MD

Sir Michael Rutter, MD, has been a consultant psychiatrist at the Maudsley Hospital in London, England, since 1966. In his lecture, he describes “How longitudinal study findings have changed our thinking over the last 50 years” beginning from that date, a time that is fresh in his mind. This was also the year his first book, *Children of Sick Parents: An Environmental and Psychiatric Study*, was published.

Sponsored by AACAP’s History and Archives Committee and supported by David W. Cline, MD.
JAMES C. HARRIS, MD, DEVELOPMENTAL NEUROPSYCHIATRY FORUM
Neurodevelopmental Consequences of Early Childhood Adversity: Insights From Children Raised in Institutions
Thursday, October 26
8:30 am–11:00 am (open)
Chair: Bryan H. King, MD, MBA
Speakers: Michael Rutter, MD, Charles Nelson, III, PhD

This Forum details the course of neurodevelopmental outcomes arising from profoundly depriving environments. The speakers focus on how early childhood deprivation impacts trajectories in childhood and adolescence, as well as promising avenues for future impact, including beneficial effects of more enriched environments, such as foster care.

The first speaker, Sir Michael Rutter, MD, was the first professor of child psychiatry in the United Kingdom and Commonwealth. He is a pre-eminent leader in developmental neuropsychiatry research, and is currently a Professor at the Institute of Psychiatry in King’s College London. Dr. Rutter is widely credited in many areas of child psychiatry, including epidemiology and genetics of autism, resilience in the face of adversity, and the sequelae of profound childhood deprivation. In this Forum, he focuses on his seminal work from the English and Romania Adoptees (ERA) study, a “natural experiment” in which there was a rapid transition from a profoundly depriving environment in Romanian institutions of the 1980s and early 1990s to adoptive families in England.

The second speaker, Charles A. Nelson, PhD, is a renowned developmental psychologist and neuroscientist who is a Professor of Pediatrics and Neuroscience at Harvard Medical School and Research Director of Developmental Medicine at Boston Children’s Hospital. His research examines the intersection of brain and cognitive development. His specific interests are concerned with the effects of early experience on brain and behavioral development, particularly the effects of early biological insults and early psychosocial adversity. In this Forum, Dr. Nelson presents his seminal work in the Bucharest Early Intervention Project, a randomized clinical trial of foster care for institutionally reared children.

During the discussion, both speakers describe how an understanding of early psychosocial deprivation influences development of children and adolescents, especially as it pertains to neurodevelopmental sequelae and risk of neurodevelopmental disorders.

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

TOWN MEETING
Breaking Down AACAP’s Communications Efforts: Protocols, Responses, and Getting the Job Done!
Thursday, October 26
11:45 am–1:15 pm (members only)

Get a firsthand look behind the curtain as AACAP’s Communications Team along with member-experts from various AACAP Committees including: Media, Disaster, and Consumer Issues, walk you through our strategies including crafting and developing communications plans, choosing when and how to respond, identifying key stakeholders, interacting with the media, adhering to message discipline, and more.

LAWRENCE A. STONE, MD, PLENARY
Child Psychiatry: This is Where We Build Healthy Brains
Friday, October 27
11:45 am–1:15 pm (open)
Chair: Gregory K. Fritz, MD, AACAP President, presiding
Speaker: James J. Hudziak, MD

James J. Hudziak, MD, is Professor of Child Psychiatry, Medicine, Pediatrics, and Communication Sciences at the University of Vermont’s Larner College of Medicine and Medical Center. He holds adjunct professorships in child psychiatry at Washington University in St. Louis, MO, Sophia Children’s Hospital at Erasmus MC Rotterdam, Netherlands, and the Giesel School of Medicine in Hanover, NH. He is the Chief of Child Psychiatry and Director of the Vermont Center of Children, Youth, and Families, and the Wellness Environment at the University of Vermont. Jim has served as the chair of AACAP’s Health Promotion and Prevention Committee for the past 6 years.

Dr. Hudziak is internationally known for his work in genomics, developmental neuroimaging, epigenetics, and assessment of child emotional behavioral problems and wellness. He has applied the neuroscience lessons from his published work of over 180 peer reviewed papers to the practice of child psychiatry. He currently holds grants from NIH and the Conrad Hilton Foundation for his work in health promotion. His publications focus on the importance of using health promotion strategies to improve brain health in children and families with the goal of impacting overall child and family emotional behavioral and general medical health.
In his lecture, Dr. Hudziak explores how the neuroscience of family-based health promotion has developed to the point that child psychiatry can take its place as a driver of health care reform. He argues that all health results from emotional behavioral health, and that in the same way cardiology has worked as a field to develop strategies to develop healthy hearts, it is time for child psychiatry to develop programs aimed at promoting healthy brain development in children and families regardless of their psychiatric status. He presents data from multiple studies using his clinical model, the Vermont Family Based Approach (VFBA). The VFBA is built on careful assessment of family emotional strengths and weaknesses. Once done, the VFBA prescribes tailored health promotion, illness prevention, and family based intervention. Dr. Hudziak presents examples from general pediatric, OB/GYN, and teenage population projects that all arrive at the same conclusion; child and adolescent psychiatrists can and should prescribe health promotion strategies with the goal of helping children and their parents ‘build healthy brains’. 

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

**PRESIDENTIAL INTERVIEW**

**Gregory K. Fritz, MD, Interviews Charles H. Zeanah, Jr., MD**

Saturday, October 28
11:45 am–1:15 pm (open)

Charles H. Zeanah, Jr., MD, is the Mary Peters Sellars-Polchow Chair in Psychiatry, Professor of Psychiatry and Pediatrics, and Vice-Chair for Child and Adolescent Psychiatry in the Department of Psychiatry and Behavioral Sciences at the Tulane University School of Medicine in New Orleans. He also directs the Institute of Infant and Early Childhood Mental Health at Tulane University. Throughout his career, he has studied the effects of adverse early experiences on development, including trauma, abuse, and neglect. He also has studied interventions designed to enhance recovery following exposure to adverse experience. He is the editor of three editions of the *Handbook of Infant Mental Health*, and with Charles Nelson and Nathan Fox, the co-author of *Romania’s Abandoned Children: Deprivation, Brain Development and the Struggle for Recovery*. He chaired a Zero to Three Task Force that recently published the DC:0–5, a diagnostic nosology for Early Childhood Disorders. A Distinguished Life Fellow of the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, he also serves as a Board Member of Zero to Three and is Visiting Professor at the University of Bucharest and the University of Glasgow.

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](http://www.aacap.org).

**By Fax/Mail:** Download and print a publication order from [www.aacap.org/moc](http://www.aacap.org/moc).

**By Phone:** Call 202.587.9675 to place your order over the phone.

For questions about Module 14 or maintenance of certification, please contact [cme@aacap.org](mailto:cme@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.
**2017 Annual Meeting Self-Assessment Exam**

Registration for the Annual Meeting allows you to take advantage of this ABPN-approved self-assessment activity for **FREE**. Complete the 100-question exam and earn **8 AMA PRA Category 1 Credits** that count toward the CME and self-assessment requirements of MOC. Use feedback from the exam to guide your selection of programs at this year’s Annual Meeting. This exam will be available until November 6.

**Not Attending the Annual Meeting?**

You can purchase access to the 2017 AACAP Annual Meeting Self-Assessment Exam online at [www.aacap.org/annualmeeting/2017](http://www.aacap.org/annualmeeting/2017).
AACAP’S 64TH ANNUAL MEETING

Discover Washington, DC!

Washington, DC, Memorials and Museums

No trip to Washington, DC, is complete without experiencing some of its world-class cultural institutions, and the National Mall is a great place to start. This famous stretch of national park, nicknamed “America’s front yard”—lays claim to one of the world’s densest concentrations of memorials and museums. Popular spots along the National Mall include the Washington Monument, Lincoln Memorial, Vietnam Memorial, National World War II Memorial, the U.S. Capitol Building, the brand new Smithsonian National Museum of African American History and Culture, the United States Holocaust Memorial Museum, the National Gallery of Art, the National Air and Space Museum, and many other Smithsonian Institution Museums!

Family Friendly Fun in Washington, DC

National Zoo

One of the most kid-friendly places to visit in Washington, DC, is the National Zoo where you can see more than 400 different species of animals. The National Zoo is set within the beautiful Rock Creek National Park and is a part of the Smithsonian Institution. Admission is FREE! Favorite animals include giant pandas, elephants, Komodo dragons, lions, giraffes, bears, and orangutans. Daily programs include animal training, feeding demonstrations, and keeper talks. Best of all, it’s just a short walk from the host hotels.

National Geographic Museum

Explore the world and all that’s in it at the National Geographic Museum. Great for all ages, the museum features a variety of changing exhibitions, from interactive experiences to stunning photography. Celebrating over 125 Years of educating people about our world, the Museum provides a unique perspective from renowned explorers, photographers, and scientists to inspire people to care about the planet.

Admission:
General – $15
Children 5 to 12 years old – $10
Children 5 & under – free

Here are just a couple of highlights of what Washington, DC, has to offer. To learn more about DC and the sites to see, visit: www.aacap.org/AnnualMeeting/2017 and washington.org/!
United States Botanic Garden

Visit the U.S. Botanic Garden for a scavenger hunt that sends kids off to identify plants and get their passports stamped. Stop in the Children’s Garden so kids can play in the playhouse, pump water, dig with shovels, water plants, and on occasion, help the staff plant flowers.

Admission is FREE!

Travel to and Around Washington, DC

There are three airports in the DC area that are in proximity to our Annual Meeting in Washington, DC: Ronald Reagan Washington National Airport (DCA), Washington Dulles International Airport (IAD), Baltimore/Washington International Thurgood Marshall Airport (BWI).

Parking at the Washington Marriott Wardman Park:
Parking is $45 USD daily

Parking at the Omni Shoreham Hotel:
Parking is $49 USD daily

Climate

October’s average high in Washington, DC, is 65°F (18.3°C) and the average low is 45°F (7.2°C). The average precipitation in October is 3.40 inches.

Don’t Forget to Book Your Hotel!

Hotels

Rooms are selling quickly at the Washington Marriott Wardman Park and the Omni Shoreham Hotel, so don’t wait to book! The Washington Marriott Wardman Park and the Omni Shoreham Hotel are located one block away from each other. Educational events take place at both the Marriott and Omni. Both hotels are conveniently located in the heart of Washington, DC, just steps from the beauty of Rock Creek Park, the wonder of the National Zoo, and world-wide cuisine of Adams Morgan.

Rates at the Washington Marriott Wardman Park are $272 single/double per night + tax. Rates at the Omni Shoreham Hotel are $274 single/double per night + tax.

It is likely that hotel rooms will be sold out by October, so don’t wait; book your room today!

Two different ways to make reservations:
1. Phone: Call the hotel directly and ask for the AACAP 2017 Annual Meeting Rate.
2. Online: Visit www.aacap.org/AnnualMeeting/2017/hotel and click on the link next to either hotel.

Hotel Policies

When making your reservation, ask for AACAP’s 2017 Annual Meeting to qualify for the reduced rate.

A deposit equal to one night’s stay is required to hold each individual’s reservation. Such deposit shall serve to confirm the reservation for the date(s) indicated and, upon check-in. This deposit is non-refundable.

The regular rate is available until Friday, September 29, or until the group block sells out, whichever comes first. We recommend making your reservation early to secure your room.

All guest sleeping rooms include complimentary internet access.

Washington, DC, sales tax rate is 14.8%.

Hotel Policies

When making your reservation, ask for AACAP’s 2017 Annual Meeting to qualify for the reduced rate.

All reservations must be guaranteed with a major credit card. Any guaranteed reservation not cancelled 7 days prior to arrival will be subject to a two night room and tax cancellation fee. Any reservations that are cancelled 30 days to 7 days prior to arrival will be charged a one night room and tax penalty fee. This rate is available until Friday, September 29, or until the group block sells out, whichever comes first. We recommend making your reservation early to secure your room.

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The Washington, DC, sales tax rate is 14.8%.
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.

Questions? Contact Elizabeth Hughes, Deputy Director of Education and Recertification, at ehughes@aacap.org, or Quentin Bernhard III, CME Manager, at qbernhard@aacap.org.
Save the Dates

January 26-27, 2018

Laurence L. Greenhill, MD and Jeremy M. Veenstra-VanderWeele, MD, Co-Chairs
New York Marriott at the Brooklyn Bridge—Brooklyn, NY

Questions? Email meetings@aacap.org.
**Funds raised as this issue goes to print:**

$159,715 – join us!

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**Break the Cycle at a Glance**

- **Starts:** August 17, 2017 – Seattle, WA
- **Ends:** October 22, 2017 – Washington, DC
- **Days:** 60
- **States crossed:** 21 + DC
- **Local events:** 9*
- **Estimates [and daily averages]:**
  - **Distance:** 5,067 [82] miles
  - **Ascent:** 196,114 [3,163] feet
  - **Time on saddle:** 496 [8] hours
  - **Burn:** 279,000 [4,500] calories

*Interested in learning how your regional organization can sponsor a local event? Visit breakthecycle.aacap.org/tools/#event.

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**Mission and Impact**

- **Your donation directly supports AACAP’s Campaign for America’s Kids (CFAK).**
- **CFAK’s mission is to support innovative initiatives in advocacy, education, and research that improve access to mental health treatments for all children.**
- **A small donation-per-mile can go a long way!**
- **Please consider giving:**
  - $50 (2¢ per mile)
  - $100 (a nickel per mile)
  - $250 (an average hourly clinical fee, or a dime per mile)
- **Giving and fundraising is easy and secure through the BtC website:** breakthecycle.aacap.org/donate/.
- **Our peer-to-peer platform can help you raise funds by reaching out via email or social media to others who support your commitment to children and families.**
- **Funds raised as this issue goes to print:** $159,715 – join us!
Please join us to *Break the Cycle* of children’s mental illnesses!

A big Thank You to all the families, members, programs, and Regional Organizations that have made this trip – so far – so incredibly special! You are the real superstars!
Renew Early for 2018

Don’t procrastinate! Make the effort and get it out of the way! AACAP 2018 dues invoices drop in early October.

Renew today at [www.aacap.org](http://www.aacap.org)!

DID YOU KNOW?

Washington, DC, is named after Christopher Columbus.
Welcome New AACAP Members

Maria Aguilo-Seara, DO, Montgomery Village, MD
Salmahn Alam, MD, New York, NY
Oday Alsarraf, MD, PHD, Charleston, SC
Sameera Azeem, MD, Evans, GA
John Banks, III, Cranberry Twp, PA
Daniella Bannikov, DO, Long Island City, NY
Timothy Becker, Philadelphia, PA
Kristin Bevington, Worcester, MA
Bishara Bhasi, MD, Harrison, NJ
Chelsey Bithell, Fontana, CA
Kimothi Cain, MD, Albuquerque, NM
Lesley D. Carew, MD, Western Cape Town, South Africa
Leela Chakravarti, Philadelphia, PA
Scott Theodore Chanatry, MD, New York, NY
Jaclyn D. Chua, DO, Stony Brook, NY
Sebastian Cisneros, MD, Bloomfield, NJ
Anne Marie Crowell, MD, Western Cape Town, South Africa
Leela Chakravarti, Philadelphia, PA
Scott Theodore Chanatry, MD, New York, NY
Jaclyn D. Chua, DO, Stony Brook, NY
Sebastian Cisneros, MD, Bloomfield, NJ
Anne Marie Crowell, Chicago, IL
Sumi T. Cyriac, MD, Livonia, MI
Tiffany DeHondt, MD, Detroit, MI
Nicole Elizabeth Derish, MD, New York, NY
Brian Donatelli, MD, Glen Oaks, NY
Alexander Eksir, MD, Durham, NC
Thomas D. Epiphight, MD, Shaker Heights, OH
Jordan Feltes, Saint Louis, MO
Robert J. Figman, MD, New York, NY
Latoya Frolov, MD, Burlingame, CA
Krysta Frye, Philadelphia, PA
Jason Garner, MD, Seattle, WA
Sanju George, MD, Philadelphia, PA
Joseph Hall, MD, Lexington, KY
Tahsin Hasan, MD, Jamaica, NY
Randeep Hayer Gandhi, MD, Scottsdale, AZ
Rebecca Hicks, MD, Boston, MA
Mikal Hicks-Black, DO, Mantua, NJ
Jesse Hinckley, MD, Aurora, CO
Gabrielle Hodgins, Miami Beach, FL
Holly Hunter, MD, Little Rock, AR
Martha J. Ignaszewski, MD, Boston, MA
Joseph Ikekwere, MD, MPH, Johnson City, TN
Kelly Irons, MD, Salt Lake City, UT
Naima Javaid, MD, Syracuse, NY
Elon R. Jeffy, MD, Tulsa, OK
Sanjay Kaji, MD, Augusta, GA
Prabhpeet Kaur, MD, Elizabeth, NJ
Simarpeet Kaur, MD, Queens Village, NY
Aubrey Klach, MD, Boston, MA
Sindhura Kunaparaju, MD, Egg Harbor City, NJ
Hope Laurie Kurens, MD, Cambridge, MA
David Latov, MD, New York, NY
Aarun S. Leekha, MD, St. John’s Newfoundland, Canada
Arthur Leitze, MD, Loma Linda, CA
Jennifer Lippitt, MD, Milwaukee, WI
Danielle Lowe, Charleston, SC
James Lubin, MD, Jamaica, NY
Austin Luker, MD, Birmingham, AL
Nandhini Madhanagopal, MD, Chapel Hill, NC
Brenda A. Manoharan, MD, Chicago, IL
Alison McCanon, MD, Norfolk, VA
Michal McDowell, Boston, MA
Christel M. Middeldorp, MD, PhD, South Brisbane, QLD, Australia
Maisarah Momen, MD, Augusta, GA
Caroline Nardi, Little Rock, AR
Sarah Nattel, Bronx, NY
Rachel Ofison, Albany, NY
Uzoamaka V. Onyejiaka, MD, Durham, NC
Allyson Oshiro, MD, Boston, MA
Zeynep Ozinci, MD, Flushing, NY
Katherine Pan, MD, Stony Brook, NY
Vanessa Patel, MD, Royal Oak, MI
Markian Pazuniak, MD, Philadelphia, PA
Latika Phillips, MD, Visalia, CA
Edward Rabe, MD, PhD, Cambridge, MA
Armin Raznahan, MD, PhD, Bethesda, MD
Abhishek Reddy, MD, Birmingham, AL
Abishek Reddy, MD, Lexington, KY
Audra Ryan-Shepard, MD, MPH, Durham, NC
Adam J. Sagot, DO, Philadelphia, PA
Charlotte Schwarz, Edison, NJ
Reem Shafi, MD, Rochester, MN
Anuj Shukla, MD, Bossier City, LA
Kunmi Sobowale, MD, New Haven, CT
Heather A. Spain, MD, Omaha, NE
Benjamin Spurling, Tampa, FL
Lucy Sung, Sacramento, CA
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Chaim Szachtel, Monsey, NY
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Alyssa Bianca Velasco, Arcadia, CA
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Vincent Wu, Naperville, IL
Emily Young, Riverside, CA
Billy J. Zou, MD, Cambridge, MA
Gifts Received May 1, 2017 to June 30, 2017

$1,000 to $2,499
Break the Cycle
Sally McDermott
Seattle Children's Foundation

Life Members Fund
Michelle Cozens*

Marc Amaya Fund
Ritz Ray, MD

$500 to $999
Break the Cycle
Debra Kiss, MD
Oregon Council of Child and Adolescent Psychiatrists
Wilbert Yeung, MD
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Mental Health and Addiction Network
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Break the Cycle
Anna Muelling, MD
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FOREIGHT CONTENT Retrieval System (OCR)
CLASSIFIEDS

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 18-bed inpatient mental health unit for children and adolescents, clinical coverage for one of two inpatient teams, some outpatient/consultation-liaison 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: 10125444
http://jobsource.aacap.org/jobs/10125444

MEDICAL DIRECTOR OF THE INPATIENT UNIT OF ONE OF THE NATION’S LEADING CHILDREN’S HOSPITALS

Job Description:
We’re seeking a Board-Certified Child and Adolescent Psychiatrist to serve as Medical Director of the Inpatient Unit for CHOC Children’s Specialists in picturesque Orange County, California. Serving at The Children’s Hospital of Orange County (CHOC), in conjunction with the University of California at Irvine (UCI), the Medical Director will provide clinical and programmatic leadership to a new state-of-the-art 18-bed inpatient mental health unit for children and adolescents, and provide clinical coverage for one of two inpatient teams. This position will also supervise child and adolescent psychiatry fellows as well as some outpatient/consultation-liaison service. The successful candidate will be eligible for an academic appointment commensurate with experience with the University of California Irvine School of Medicine as well as clinical privileges in the Department of Psychiatry and Human Behavior at UCI. A range of research opportunities are available both at CHOC and UCI. CHOC Children’s Specialists, a private pediatric subspecialty group, is composed of more than 180 physicians and 19 pediatric subspecialties. The group practices at CHOC Children’s, a premier healthcare system based in Orange County, California. Named as one of the best children’s hospitals by U.S. News and World Report (2017-2018) and to The Leapfrog Group’s 2016 Top Children’s Hospitals list for safety and quality, CHOC Children’s is also among only 7 percent of hospitals awarded Magnet designation for nursing excellence, and recognized by Press Ganey for excellence in physician engagement with families. One of California’s most sought-after areas, Orange County is situated between San Diego and Los Angeles, and includes 45 miles of gorgeous coastline. Orange County is home to such iconic beach communities as Newport Beach, Laguna Beach, Huntington Beach and Dana Point. In your off-hours, surf the waves, go paddle boarding or hit the golf course. Stroll the piers and enjoy world-class shopping and dining. Catch some professional sports. And Disneyland and Knott’s Berry Farm are right in your backyard. The weather is picture perfect year-round, with plenty of sunshine. The California lifestyle doesn’t get any better than this! And families will appreciate the area’s top-notch schools and friendly and safe neighborhoods. You’re less than an hour’s drive from Los Angeles, less than 90 minutes from San Diego and about two and a half hours from Santa Barbara.

Job Requirements:
Candidates must possess an MD degree, be Board-Certified in Child and Adolescent Psychiatry and possess or be eligible for a permanent California medical license.

Company: Pediatric Search Partners
Job ID: 10125438
http://jobsource.aacap.org/jobs/10125438

BC/BE CHILD PSYCHIATRIST

Job Description:
BC/BE CHILD PSYCHIATRIST NEEDED in Beautiful Santa Cruz, CA. Welcome to the #1 place in California to live and the 3rd best place to live in the country! I am looking for a BC/BE child psychiatrist for a private practice located in Santa Cruz, CA, just about 1 hour south of San Francisco. The position is strictly outpatient without call. All administrative duties such as; scheduling, billing and coding are included. The position is $125 per hour. Your income is based on how many hours you choose to work. The practice is currently turning patients away and is booked through the end of 2017. The office is available Monday through Thursday after 5 pm and all day Friday through Sunday. Please fax or email your curriculum vitae to 831-477-9908 | office@drsdass.com.

Job Requirements:
Valid CA Medical License (in good standing) REQUIRED

Company: Shermeil K. Dass, M.D., APC
Job ID: 10096324
http://jobsource.aacap.org/jobs/10096324

CONNECTICUT

PART-TIME CHILD PSYCHIATRIST

Job Description:
Bridges Healthcare, Inc. provides a comprehensive range of outpatient mental health, addiction, community support and home-based services for children, families and adults residing in our local communities. We are currently inviting applications for a Part-Time Child Psychiatrist in our Milford, Connecticut location. Child Psychiatrist will provide psychiatric evaluations and treatment to
children/adolescents. They will provide clinical consultation to non-medical staff, develop and maintain relationships with community providers, maintain client records and have supervisory responsibility. The position requires completed residency in psychiatry, completed fellowship in child and adolescent psychiatry, and board certification in Child and Adolescent Psychiatry. Experience in treating substance-use disorders is preferred. A current State of CT physician license, CT controlled substance registration and Federal DEA certificate is required. Part-time hours (5+ hours per week), weekdays. Hourly rate is commensurate with experience. Send your CV to Recruiting@bridges-milford.org. Inquiries from qualified individuals regarding the positions are welcome, but no recruiters or locum tenens agencies, please. We regret that we cannot provide relocation assistance for this position. Affirmative Action / Equal Opportunity Employer / Minorities / Females / Disabled / Veterans

Company: Bridges Healthcare, Inc.
Job ID: 10185270
http://jobsource.aacap.org/jobs/10185270

MARYLAND
PSYCHIATRY FACULTY, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY

Job Description:
The Johns Hopkins University Department of Psychiatry, Division of Child and Adolescent Psychiatry is seeking either child and adolescent psychiatrists or psychologists committed to a career in academic medicine. Successful candidates will be superb clinicians or investigators committed to improving the lives of children and adolescents suffering from psychiatric disorders through direct patient care, research, and/or education. Open rank, clinical and research faculty appointments within the Department of Psychiatry and Behavioral Sciences are available commensurate with background and experience. Positions have the potential to provide a mixture of clinical, teaching and research opportunities dependent upon interest and skills of the faculty member. Leadership opportunities are available. The Johns Hopkins University provides excellent benefits including partial college tuition grant for dependents (at any college) and tuition remission for faculty members, spouses, and dependents for coursework completed at the Johns Hopkins University and Peabody Music Institute. The Johns Hopkins University is an equal opportunity/affirmative action employer committed to recruiting, supporting, and fostering a diverse community of outstanding faculty, staff, and students. All applicants who share this goal are encouraged to apply. Contact: Robert Findling, MD, MBA, Director, Child and Adolescent Psychiatry, The Johns Hopkins University School of Medicine. Phone 410-955-2320. Email: rfindli1@jhmi.edu

Job Requirements:
Board-Certified or Eligible in Child and Adolescent Psychiatry; Licensed Clinical Psychologist

Company: Johns Hopkins University
Job ID: 10076453
http://jobsource.aacap.org/jobs/10076453

BC/BE C AND A PSYCHIATRIST

Job Description:
Dear Colleague – I am recruiting for a BC/BE psychiatrist for the THRIVE Center in Columbia, MD. The position involves medication management services for two specialty programs: 1) ADHD/Executive Function Disorder; and 2) Intensive treatment of failure to launch young adults. The successful candidate will be committed to building a long-term relationship with our center; and will possess the ability to work closely in a tightly coordinated treatment team. I am most interested in candidates with expertise in some or all of the following clinical areas: Attention Deficit/ Hyperactivity Disorder Child and Adolescent Psychiatry The struggling to launch young adult population Specialization in or experience with substance and process addictions. Experience with psychotherapy in addition to medication management Experience with intensive, wrap around outpatient programs if the applicant is a more experienced clinician, I would be willing to discuss the possibility of medical director responsibilities in addition to the medication management duties. Compensation is negotiable and competitive. Opportunities@myTHRIVE.net, Rick Silver, MD

Company: THRIVE Center for ADHD and Comprehensive Mental Health Care
Job ID: 10201982
http://jobsource.aacap.org/jobs/10201982

NORTH CAROLINA
FULL/PART-TIME CHILD AND ADOLESCENT PSYCHIATRIST

Job Description:
SEEKING FULL- or PART-TIME CHILD AND ADOLESCENT PSYCHIATRIST (BE/BC) to join an established, growing multispecialty group practice at our newly expanding office in Cary, NC. Out-patient only, fee-for-service, busy, no managed care, working with other psychiatrists, psychologists and educators in a family-oriented practice and community consistently rated as the top place to live in the country. Just minutes from RTP and 3 major universities. Flexibility in job, excellent collections and benefits. Email CV to Office Manager, Jyoti Gawdi at jgawdi@fppa.com. Website: www.fppa.com

Company: Family Psychiatry and Psychology Associates, P.A.
Job ID: 10111689
http://jobsource.aacap.org/jobs/10111689

PENNSYLVANIA
EXCITING CHILD AND ADOLESCENT PSYCHIATRIST OPPORTUNITY IN THE SOUTHERN SUBURBS OF PITTSBURGH, PA!

Job Description:
We are currently accepting BC/BE Child and Adolescent Psychiatrist CVs for an exciting full-time opportunity within the Allegheny Health Network in Pittsburgh, Pennsylvania. Our Department of Psychiatry is growing rapidly and this is an excellent opportunity for experienced providers and graduating fellows alike. The position will provide psychiatric services at Jefferson Hospital’s outpatient clinic located in the southern suburbs.
of Pittsburgh, PA. The candidate will see a wide variety of cases, with ample opportunity for patient education and follow-up. In addition to a competitive compensation package— including health insurance, retirement benefits, paid malpractice, CME allowances and more—the position offers regular and predictable schedules, teaching opportunities, and an exceptional support staff within a collegial environment. Allegheny Health Network (AHN) is comprised of eight hospitals: Allegheny General, Allegheny Valley, Canonsburg, Forbes, Jefferson, Saint Vincent, Westfield Memorial and West Penn; and more than 200 primary- and specialty-care practices. And we have approximately 1,700 physicians in every clinical specialty, 17,000 employees and 2,000 volunteers. Together, we provide world-class medicine to patients in our communities, across the country and around the world. AHN is located in Pittsburgh, PA. Pittsburgh is a vibrant and exciting city, offering diverse culture, world-class arts and music, prestigious colleges and universities, proximity to state and local recreational parks, and a nationally recognized culinary scene. It is home to major sports teams as well as key players within an ever-growing tech industry. Pittsburgh’s beautiful landscape, rivers and bridges, and affordable cost of living make it an attractive option for both individuals and families. For more information, contact Jessica Vega, Physician Recruiter at Allegheny Health Network Phone: 412-330-6042 | E-Mail: jessica.vega@ahn.org

**Job Requirements:**

BC/BE in Psychiatry C and A Psychiatry Fellowship Trained BC/BE in Child and Adolescent Psychiatry Eligible for a PA Medical License and DEA

**Company:** Allegheny Health Network (1052691)

**Job ID:** 10134028

http://jobsource.aacap.org/jobs/10134028

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**SOUTH CAROLINA**

**EMERGENCY PSYCHIATRIST - GREENVILLE, SC**

**Job Description:**

Emergency Psychiatrist Greenville, SC

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.

**Company:** Greenville Health System (928051)

**Job ID:** 10196409

http://jobsource.aacap.org/jobs/10196409

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**DID YOU KNOW?**

The Washington Monument is (accidentally) two different colors, and is the tallest stone structure in the world.
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Commission for advertising agencies not included.

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January/February 2018 . . . . . . . . . . . November 27
March/April 2018 . . . . . . . . . . . . . January 27, 2018
May/June 2018 . . . . . . . . . . . . . . . . March 27, 2018
July/August 2018 . . . . . . . . . . . . . . . . May 27, 2018

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Advertisers who run ads three issues in a row receive a 5% discount.
Advertisers who run ads six issues in a row receive a 10% discount.

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