Child and Adolescent Psychiatric Society of Greater Washington

CAPSGW

Fall/Winter 2014

Inside this issue:

President's Message

Rebecca Edelson, MD

Welcome to the winter edition of the CAPSGW newsletter.

As always, I want to thank our newsletter editor Dr. Martine Solages for an excellent newsletter. Martine took over this role last spring and thus far, she has done a masterful job editing and organizing our newsletter. I also want to thank our CAPSGW executive administrator Ms. Diane Berman for her work with this edition. As this is my final newsletter as CAPSGW's president, I want to take this opportunity to thank Diane for her endless dedication to CAPSGW. Over the years, we have shared many late night emails. I also want to especially thank our president-elect Dr. Micah Sickel. I know he will do an excellent job in the role as president!

As I have done in my previous president's messages, I will take this opportunity to highlight some of CAPSGW's accomplishments over the last six months as well as tell you about some of the highlights in this issue.

Educate

We have already had two dinner events this fall. We kicked off with a small "salon" at the home of CAPSGW member Dr. Patricia Carrington. Dr. Ken Towbin gave a stimulating talk about severe mood dysregulation and pediatric bipolar disorder. This was CAPSGW's first salon and clearly by the rapid RSVP rate (we had 25 responses within 24 hours) and positive evaluations, this is a format that will be repeated in the future. Please read more about this exciting salon in the article by president-elect Dr. Micah Sickel. Our second dinner meeting was on November 5 at Maggianos. Dr. Adelaide Robb gave a data packed talk on the pharmacologic updates for the treatment of mood disorders and psychosis. Please read the article by newsletter editor Dr. Martine Solages for more details.

Advocate

Last June, Dr. Marc Dalton (our CAPSGW DC Representative) and I submitted a written "statement of support" in reference to a hearing regarding reparative therapy and minors. The Honorable Yvette Alexander was proposing an amendment banning any licensed mental health practitioner in the District of Columbia from engaging in any therapy or treatment modality aimed at changing the sexual orientation of a minor. The Committee on Health was requesting live and written testimony for the hearing. In response, Dr. Dalton and **I** submitted a written statement of support, which was in accordance with AACAP guidelines, to the DC Council. The statement was entered into the official record. Please read more follow-up about this in the article by Dr. Mark Dalton in this issue.

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President's Letter *(Continued from page 1)*

I also encourage you to read the article by Dr. Finza Latif describing her participation this summer in a congressional briefing on Capitol Hill about the importance of early intervention in children's mental health.

In October, CAPSGW sent five delegates to the AACAP Meeting in San Diego, California. As always, the meeting serves as an important opportunity for our delegates to learn about child psychiatry activities around the country. Please read the article by Dr. Adair Parr to learn more about the meeting. Please also mark your calendars for AACAP Advocacy Day on April 23-24 in Washington, DC. CAPSGW continues to have good turn out and I hope we will continue to expand this spring.

Nurture

For the third year, CAPSGW was pleased to offer travel grants for $500 each for a resident to attend the AACAP Annual Meeting in San Diego, California. The two grants this year were awarded to Dr. Kurt A. Brown, Child and Adolescent Psychiatry Fellow, MedStar Georgetown University Hospital and Dr. Vujayabharathi (VJ) Ekambaram, Child and Adolescent Psychiatry Fellow, Children's National Medical Center. CAPSGW was also thrilled to offer $150 to Dr. William Cohen, Child and Adolescent Psychiatry Fellow, Medstar Georgetown University Hospital, to help support his travel expenses to the AACAP meeting. Please read articles by all three winners in this issue to learn about their AACAP meeting experiences.

Our Early Career Psychiatry (ECP) sub-committee continues to be busy planning events for our members. The committee hosted a career panel luncheon in June and a joint Maryland Regional Council-CAPSGW welcoming event in November. I want to thank the committee co-chairs Drs. Sonali Mahajan and Clifford Sussman for their commitment and perseverance in continuing to make these events happen! Please read their article to learn more details about the events.

I encourage you to read the article by Dr. Richard Gross to learn a bit more about CAPSGW's history and how our meetings have changed over the years.

Finally, I want to recognize members who are leaving our CAPSGW Executive Committee (EC). Dr. Adair Parr has served as assembly delegate for the last three years. She also served as newsletter editor before that. Dr. Marc Dalton served as DC representative for the past two years. Thank you both. I also want to congratulate our recently elected members to the CAPSGW Executive Committee: Dr. Micah Sickel – president, Dr. Susan Rich – president-elect, Dr. Martine Solages – secretary, Dr. Caroline Cregan – treasurer, Drs. Michael Houston and Adelaide Robb - assembly representatives, Dr. Clifford Sussman – DC Representative, Dr. Haniya Raza – MD Representative, and Dr. Sonali Mahajan – VA Representative.

As always, any member of CAPSGW is welcome to attend our monthly executive committee meetings at the AACAP building in Washington, DC.

In closing, I want to thank the CAPSGW membership for allowing me to serve as your president for the last two years. I have grown personally and professionally in this role and I thank you for that.

I hope you enjoy this winter edition of the newsletter. Happy Holidays! ■

Rebecca Edelson, MD
CAPSGW President 2012-2014

Update from AACAP Assembly of Regional Organizations

Adair Parr, MD
CAPSGW Assembly Delegate

As a CAPSGW Assembly Representative, I attended the AACAP Assembly at the 2014 Annual Meeting, along with fellow Assembly Representatives Rebecca Edelson, Lisa Cullins, Michael Houston, and Jeanne Holzgrefe.

It was a busy day! The morning opened with Assembly Chair Warren Ng welcoming the 117 attendees to San Diego, California. Paramjit Joshi, AACAP President, also welcomed members of the Assembly and summarized the major accomplishments achieved over the past year. Dr. Joshi highlighted formation of the AACAP PAC (political action committee). She highlighted that overall contributions from pharmaceutical companies to the AACAP budget have decreased. Dr. Joshi discussed the international collaborations that are ongoing around the world with international psychiatry groups and AACAP.

Greg Fritz, AACAP President-Elect, discussed his presidential initiative, which is focused on collaborative care. He plans to develop an online integrated care resource center. This will include literature reports, curricula, educational tools, evaluation instruments, and policy and advocacy materials. He will be coordinating collaboration with other disciplines, including pediatricians, psychologists, and family practitioners. Many fiscal and regulatory roadblocks exist, including no payment for non-face-to-face consultation, other reimbursement issues, and HIPAA restrictions. Educational projects are part of this initiative as well.

Rich Martini, co-chair of the Committee on Collaboration with Medical Professions, explained an educational initiative, incorporating clinical experience and didactics, to collaborate between pediatrics and child psychiatry. This proposal includes use of consultation services and models of mental health integration in primary care. Mark Borer, Assembly Vice Chair, emphasized the importance of collaboration in the work of all psychiatrists. He then presented the 2014 Advocacy and Collaboration Grants: there were 10 awards this year from 13 applications. Applications for the next cycle of Advocacy and Collaboration grants are due in January 2015.

Submissions to the *AACAP News* are welcome and encouraged.

The Women in Child and Adolescent Psychiatry Committee was introduced by Debra Koss.

Discussions were held in the open forum regarding a controversial 2001 JAACAP article on paroxetine and major depression (Study 329).

Discussions were held in the open forum regarding communication in the Assembly. Throughout the day, there were heated discussions about this topic.

A member of the telepsychiatry committee, Pamela Hoffman, then presented information about telepsychiatry. A video gave an overview of telemedicine.

The day's keynote speaker, AMA Secretary Patrice Harris, MD, MA, a child psychiatrist who now works as the director of Health Services for Fulton County, Georgia, spoke to the strategic goals that the AMA has taken to address meaningful use and ICD 10. She encouraged innovative curricula for the 21st Century. This includes team based care, population health, use of electronic health records and chronic disease management. In addition, she discussed the AMA's efforts to improve health outcomes for patients in the realms of high blood pressure, diabetes, and obesity. The AMA has partnered with the YMCA to create a diabetes prevention program. She described a program developed in collaboration with Johns Hopkins to develop a framework to identify and manage hypertension, called MAP. She also gave an update on the Affordable Care Act. 7.3 million Americans have signed up through federal exchanges. Another 7 million have signed up through Medicaid expansion. She highlighted the changes in the rules for Accountable Care Organizations (ACOs) that the AMA has advocated so that physicians are currently leading about 70% of ACOs. She also discussed her role in advocacy and how participation in advocacy is important in organized medicine.

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Assembly Update *(Continued from page 3)*

After lunch, Sandra Sexson discussed the current maintenance of certification requirements. Brian Shuy, AACAP Assistant Director of Grassroots Advocacy, presented the state advocacy report. Rob Grant announced that AACAP has 8,861 members, which is a new high! 14 residency programs are in the 100% club.

The Catcher's In the Rye award was awarded to: Dr. Sahid Hussein (individual); Task Force on the Relationship Between AACAP and the Biomedical Industry (group); and the Georgia Council of Child and Adolescent Psychiatry (Regional Organization) for their efforts in coding issues for Medicaid patients.

Andres Martin, editor of *JAACAP*, discussed recent updates from the Orange Journal. He introduced *JAACAP Connect*, a new publication targeted toward those who are starting to publish. He discussed the S329 article, published in 2001, under the editorship of Mina Dulcan. Many questions had arisen at the Assembly that morning, including whether failure to disclose financial conflicts of interest had occurred, whether data was concealed, whether outcome measures were manipulated, and whether ghost writing was used. These allegations were first raised in 2002 and 2003 in letters to the editor. A review of the evidence was conducted by Dr. Martin, who took over as editor of *JAACAP* in 2008. He explained that he has found no evidence to retract the article. In July 2010, Dr. Martin finished his independent assessment deciding that there was no evidence to retract the paper. In 2012, GlaxoSmithKline plead guilty to allegations of fraud and failure to report safety data which were brought by the Department of Justice and agreed to pay a $3B fine.

Former Assembly Chair, Michael Houston, discussed the Taskforce on Healthcare Delivery Systems, which he co-chaired along with Richard Martini. Two webinars were produced in April and May 2013. They are updating membership via ongoing AACAP newsletter articles. They held a town meeting at last year's annual meeting and at this year's annual meeting. This year, the individual mandate was instituted. The employer mandate has been delayed until 2015. Dr. Martini discussed the recommendation that child and adolescent psychiatrists should be familiar with evolving models of healthcare reform. The forward focus of the task force includes the role of child and adolescent psychiatrists in new care delivery models. The structure of ACOs and the integration of mental health services must be considered. They recommend that CAPS and AACAP should support collaboration with primary care physicians and pediatric subspecialty physicians by establishing stronger relationships in training and clinical practice. A recommendation to Council was to create opportunities for collaboration with primary care in education, consultation, and patient assessment/treatment. It will also be important to identify the clinical responsibilities of CAPS in systems of care. Other recommendations included encouraging CAP involvement in pediatric health care as early as possible. These roles could be as consultant, provider of services, and/or contributors to comprehensive school health programs. Another recommendation was made to encourage training in new consultation models with multidisciplinary teams that are unlike traditional CL services.

Jeanne Holzgrefe presented an Action Item to the Assembly about improving communication to members about ongoing efforts of AACAP regarding implementation of the ACA. She explained that her concerns arose from an interaction on the CAPSGW Listserve discussing the recent changes in providing medications as a Medicaid provider. She suggested that, as members of AACAP, we be informed about such changes prior to their implementation in order to provide us time to make a thoughtful decision about our actions as child and adolescent psychiatrists. This might include periodic emails and opportunities for AACAP members and staff to become more actively involved in legislative issues.

Debra Koss discussed the findings of the task force on the relationship between AACAP and the biomedical industry. The task force examined AACAP conflict of interest policies and educational materials. ROCAPs were surveyed and AACAP membership was surveyed. The task force decided that the benefit of having interactions with the biomedical industry was important. However, it is important to manage the relation

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Assembly Update *(Continued from page 4)*

ship with industry responsibly. Read more about the task force's findings here.

Alan Axelson, Delegate from the Pittsburgh Regional Council, discussed the importance of education regarding the boundaries of HIPAA in clinical practice. A resolution was passed. Bela Sood discussed HIPAA and FERPA. She cited the Virginia Tech tragedy as a situation in which providers hid behind HIPAA, which interfered with patient care. Sherry Barron-Seabrook gave an update on coding. The CPT Coding group was given an education award for ducating the members.

Warren Ng thanked those Representatives to the Assembly who are rotating off and closed the Assembly. It should be noted that our current CAPSGW President, Rebecca Edelson, will rotate off the Assembly once her term concludes and that Micah Sickel, President-Elect will assume her position. As one of the CAPSGW Assembly Representatives who is rotating off I thank you for allowing me to represent you. Adelaide Robb will be a new Assembly Representative starting in 2015. Michael Houston will continue as an Assembly Representative for another three-year term. ■

Early Career Psychiatrist (ECP) Sub-Committee Update

Recently two events were sponsored by the CAPSGW Early Career Psychiatry (ECP) committee: a Career Panel Luncheon and a joint Maryland Regional Council-CAPSGW welcoming event. Both events were organized by Sonali Mahajan, M.D. and Clifford Sussman, M.D., ECP committee co-chairs.

The Career Panel Luncheon took place on Saturday June 21, 2014 at the Psychiatric Institute of Washington (PIW). It featured a panel of four accomplished colleagues: Dr. Finza Latif, Dr. Simona Murnick, Dr. William Stark, and Dr. Al Zachik. The panelists shared their wisdom and answered questions about various career paths available to those of us who have just started our journey in child psychiatry, including private practice psychiatry, hospital-based psychiatry, and public mental health. The event was well-attended by ECPs, as well as the president-elect of CAPSGW, Micah Sickel, who offered to be a resource to those interested in a military-based career. Several other seasoned child and adolescent psychiatrists volunteered to attend future events like this one.

The first CAPSGW joint event with the ECPs of the Maryland Regional Council of Child and Adolescent Psychiatry was held on Saturday, November 1, 2014, at Dave and Busters near Baltimore, MD. The goals of the event were to promote networking amongst ECPs within our regions as well as to welcome new Child Psychiatry fellows to the area. Given the distance that the CAPSGW ECPs and fellows had to travel, it was a great turnout, and the ECPs and fellows were able to connect with others on issues related to careers, family lives, as well as personal interests. The ECP committee hopes to host more of these joint events with the MD Council. ■

Sonali Mahajan, M.D., ECP Committee Co-Chair
Clifford Sussman, M.D., ECP Committee Co-Chair

Training Updates

Children's National Health System

It is hard to believe that we are already halfway through the 2014-2015 academic year! The time has flown, in large part due to the enthusiasm and energy of our nine wonderful child and adolescent psychiatry fellows. Our first year fellows – Drs. Jean Cho, Milangel Concepcion Zayas, VJ Ekambaram, Shalice McKnight, and Yuanfen Zhang have acclimated to and immersed themselves in the busy inpatient, consultation-liaison, and outpatient services. This year, the new patient Assessment Clinic rotation is based at a primary care clinic, which provides first year fellows experience providing integrated behavioral health services. Amazingly, despite their busy schedule, our first years have also taken on some extracurricular pursuits; for example, we were proud to see Dr. Ekambaram receive the CAPSGW Travel Grant to attend the AACAP Annual Meeting and to learn that Dr. Concepcion would present at the World Psychiatric Congress in Madrid about her work on human trafficking. Second year fellows Drs. David Call, Tracy Das, Adam Richmond, and Jessica Yeatermeyer continue to refine their skills through their outpatient practice, subspecialty rotations, and electives. We are pleased to offer a number of new elective opportunities for them this year, including rotations at C.A.S.E. (Center for Adoption Support and Education), Children's Law Center, RICA, and Journeys (an adolescent addictions group therapy program). Dr. Tracy Das, who completed an international rotation in Japan last year, will supplement that experience with a longitudinal global health elective at NIH this year. The second year fellows have also taken their adult psychiatry boards and are working towards completion of their scholarly projects.

There have been a number of other exciting developments at Children's, including a new initiative in telemental health with Peninsula Regional Medical Center and the upcoming launch of the DC MAP Program, through which mental health teams from Children's National and Georgetown will provide consultations to primary care providers. We congratulated Dr. Adelaide Robb, who was named Chief of Psychology and Behavioral Health. We also welcomed several new faculty members to the division of Psychiatry. Dr. Katherine Hobbs Knutson, a former Kraft Center for Community Health Fellow, has deep experience in community psychiatry and systems of care. She will be providing co-located mental health services in the pediatric primary care clinics and working with the DC MAP Program. Dr. Finza Latif is now the Director of Psychiatric-Consultation and Emergency Department Services. She has particular expertise in pediatric eating disorders and has started an outpatient eating disorders clinic in our division. Dr. Faith Rowland is the new director of the Mood Disorders Clinic and comes to Children's National with a focus on cultural competence in mental health treatment, including a specific interest in the intersection of spirituality and mental health care.

We know that the children and families in our care and the varied initiatives and projects we have undertaken will keep us quite busy for the remainder of the year, but we are up to the challenge and grateful to our fellows for their hard work and commitment. We send our best wishes to everyone in the CAPSGW community for the New Year! ■

Lisa Cullins, MD, Training Director

Martine Solages, MD, Associate Training Director

Training Updates

Georgetown University Medical Center

After seeing off our two graduating fellows, Drs. Thad Garland and Peter Mikhail, we have had a fun and engaging start to the 2014-2015 academic year here at Georgetown. Dr. Garland is now in group private practice in Fairfax, Virginia with his former supervisor, Dr. Peter Robbins, and Dr. Mikhail is doing locums tenens work in New Haven, Connecticut while his wife starts nephrology fellowship at Yale. Both of our new first-year fellows, Drs. Kurt Brown and Bill Cohen, received travel grants from CAPSGW and attended AACAP's annual meeting in San Diego. Our second-year fellows, Drs. Ivona Bendkowska and Mark Sakran, have made successful transitions to outpatient child psychiatry and are busy working on their scholarly projects and starting their respective job hunts. Dr. Sakran is working on establishing a mentoring program at Mary's Center, one of our community partners, and Dr. Bendkowska is examining the relationship between anxiety and autism spectrum disorder.

Finally, we are very excited to welcome two new staff members to our division: Aaron Rakow, PhD and Megan McCormick King, PhD. Both Drs. Rakow and McCormick King will be supervising psychologists for the department's new psychology externship in addition to seeing patients in our clinic and providing consultation in schools. ■

Colin Stewart, MD, Associate Training Director

National Capital Consortium (NCC), Uniforme Services University of the Health Sciences Walter Reed, Bethesda

The National Capital Consortium's Child and Adolescent Psychiatry Fellowship at Walter Reed welcomed two new Army fellows, CPT Jared Hagan, and CPT Michael Stachniak at the beginning of this academic year. CPT Richard Ernst, LCDR Amy Canuso, and LCDR Monica Ormeno continue through the second year of training, and welcome the opportunity to be stationed overseas upon graduation. Two of them will likely be stationed in Japan and Guam next summer. Of note, our most recent graduate, Dr. Natosha Smith, has been refining the delivery of CAP services at a U.S. Air Force Base in Alaska since here arrival in August.

This academic year has been a time of considerable expansion in response to robust feedback from fellows and faculty during our most recent curriculum and rotation review. New rotations with Adventist Behavioral Health are welcomed additions (many thanks to Dr. Eduardo Suardi and Dr. Deborah Gambles for their flexibility). Participating in elective outpatient subspecialty clinics with CNMC providers has been a highlight for 2nd year fellows (many thanks to Dr. Martine Solages and Dr. Lisa Cullins). Our fellows have benefitted from additional clinical opportunities with Walter Reed's Department of Developmental Pediatrics and from participation in an ongoing forensic lecture series at St. Elizabeth's Hospital. Fellows look forward to presenting their scholarly activity at the first annual CAP Academic Symposium, a collaborative venture created by the five regional CAP program directors in Maryland and Washington D.C, to be held in Spring 2015. Finally, CPT Hagan will be presenting at the 2015 American Psychiatric Association Annual Meeting on the topic of Cognitive Bias.

The fellowship just completed applicant interviews of Army and Navy medical officers from across the United States. We look forward to welcoming our new trainees in July. ■

Lieutenant Colonel Joseph Dougherty, MD,
Training Director

Congressional Briefing on Mental Health: *Children's Mental Health: The Importance of Early Identification and Intervention*

Finza Latif, MD

On August 15, 2014 various children's health organizations including the American Academy of Child and Adolescent Psychiatry, Children's Hospital Association, and American Academy of Pediatrics sponsored a briefing on Capitol Hill about the importance of early intervention in children's mental health.

The briefing was conducted by three panelists: Mario Hernandez, PhD, of the University of South Florida, and moderator; Tamar Magarik Haro, Associate Director, Department of Federal Affairs, American Academy of Pediatrics (AAP); and myself, Finza Latif, MD, of Children's National Health System.

National statistics show one in five American children will suffer from a mental health condition before the age of eighteen.

Ms. Haro opened the discussion by presenting statistics about the high prevalence of mental illness in children and lack of sufficient treatment resources.

National statistics show one in five American children will suffer from a mental health condition before the age of eighteen. Only 20% of those children will receive treatment and there are often delays in diagnosis and treatment. Even with federal efforts for mental health parity, barriers such as stigma and a shortage of mental health providers continue to persist.

I discussed the gap in the number of child and adolescent psychiatrists needed in the US and the number of current child and adolescent psychiatrists available. I advocated for the need to fund programs which can help close the gap such as telemedicine, collaborative care and school-based mental health programs, and incentives for students pursuing careers in mental health.

Dr. Hernandez discussed the child psychiatry access programs utilized by many states and federal programs such as the Substance Abuse and Mental Health Services Administration's Child Mental Health Initiative and the need for expanding access to Medicaid patients. He also pointed out that one of the reasons for over-medication of US youth with mental illness is due to lack of availability of community psychosocial supports.

The hearing helped educate young congressional staffers about the current burden of mental health problems and the need for making policies supporting appropriate funding for mental health resources. ■

Finza Latif, MD is the Director, Psychiatric Consultation-Liaison and Emergency Services and Director, Eating Disorders Clinic for the Children's National Health System.

Autumn Salon: Dr. Kenneth Towbin on Disruptive Mood Dysregulation Disorder

Micah Sickel, MD, Ph.D

In addition to the larger CME dinner events, CAPSGW is pleased to continue its series of salons this year. Salons are an opportunity for a smaller gathering of members to meet and learn about a topic of interest in a more intimate and interactive setting. The first salon of the 2014-15 season took place on Tuesday, September 30 at Dr. Patricia Carrington's home. This salon was the first CAPSGW has offered with CME credit attached. The combination of a top notch speaker (Dr. Kenneth Towbin, from the Emotion and Development branch of the National Institute of Mental Health), a controversial topic (Disruptive Mood Dysregulation Disorder), free food, and CME credit proved to be a huge draw, garnering 25 participants within the first 48 hours of opening registration, with nine individuals placed on the waiting list. Patti ordered a beautiful array of Mediterranean foods, including mini gyros, and all of the dishes were well picked over by the end of the salon. For the first hour, participants had a chance to dine and talk. It was a nice chance to say hello to colleagues and friends whom one had not seen in a while, as well as meet new faces. The second hour was spent listening intently to Ken talk about chronic irritability and pediatric bipolar disorder. He delved into the differences between bipolar disorder, severe mood dysregulation, and disruptive mood dysregulation disorder, a diagnosis which has first appeared in DSM V. Discussion of the topic was so involved that our President, Rebecca Edelson, had to step in to call a conclusion to the evening as we ran over the scheduled end time. Based on the surveys collected that evening, it was a rousing success and bodes well for the next salon. These are certain to be popular events, combining a less formal setting in a member's home, good food, no cover charge, and CME. What more can one ask for? Huge thanks go out to Patti, Diane, Rebecca and Ken for making the evening run smoothly. ■

Fall 2014 Election Results

Congratulations to our new officers and Assembly Delegates elected in October. The 2015 Executive Committee and Assembly Delegation will be comprised of the following members:

Executive Committee (Effective January 1, 2015—December 31, 2016)

President: Micah J. Sickel, MD, PhD

President-Elect: Susan D. Rich, MD, MPH

Secretary: Martine Solages, MD

Treasurer: Caroline Cregan, MD

DC Representative: Clifford Sussman, MD

MD Representative: Haniya Raza, MD

VA Representative: Sonali Mahajan, MD

Assembly Delegates* (Effective January 1, 2015)

Lisa Cullins, MD

Jeanne Holtzgrefe, MD, PhD

Michael Houston, MD (incoming)

Adelaide Robb, MD (incoming)

Micah Sickel, MD, PhD (as president)

* Assembly Delegates serve a three-year term.

DC Representative Update: DC Council Passes Amendment that Prohibits Conversion Therapy Use in Minors

Mark Dalton, MD, MPH

On June 26, 2014 of this year, The Honorable Yvette Alexander held a hearing on her proposed amendment to the Mental Health Services Delivery Reform Act of 2001 that sought to "prohibit the use of practices designed to change the sexual orientation of a minor by a licensed mental health provider." The Child and Adolescent Psychiatric Society of Greater Washington submitted a written statement (see letter below) for the official record to note our support of the proposed amendment. The final vote was passed unanimously on Tuesday, December 2, 2014. With that vote, the District of Columbia joined California and New Jersey as the third jurisdiction to ban therapies aimed at changing the sexual orientation of minors.

Since 1973, the American Psychiatric Association has stated that homosexuality does not meet the criteria for a psychiatric disorder and after 1973 homosexuality was removed from The Diagnostic and Statistical Manual of Mental Disorders.

Additionally, The American Academy of Child and Adolescent Psychiatry published Practice Parameters on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents in the Journal of the American Academy of Child and Adolescent Psychiatry in 2012. Of note, Parameter #6 states: "Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful."

We are proud to report on CAPSGW 's efforts to advocate for the youth of DC. ■

June 15, 2014

The Honorable Yvette Alexander
Chairperson, Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Ave, NW
Washington, DC 2004

Dear Councilmember,

The Child and Adolescent Society of Greater Washington (CAPSGW) is a regional organization of the American Academy of Child and Adolescent Psychiatry. It is a not- for profit 501 (c) 3 medical specialty organization representing approximately 250 child and adolescent psychiatrists in the District of Columbia, suburban Maryland, and Northern Virginia.

One of the main objectives of The Child and Adolescent Psychiatric Society of Greater Washington is to stimulate sion and advance contributions of the knowledge and treatment of psychiatric problems of children and adolescents, both within its membership and in the community at large, within Washington, D.C., and those adjacent states from which its membership is drawn.

CAPSGW very much appreciates and supports the proposal to amend the Mental Health Services Delivery Reform Act of 2001 to prohibit the use of practices designed to change the sexual orientation of a minor by a licensed mental health provider.

Major mental health associations have stated publically for many years that homosexuality is not a psychiatric disorder. Since 1973, the American Psychiatric Association, the world's largest psychiatric organization has stated that homosexuality does not meet the criteria for a psychiatric disorder and after 1973, homosexuality was removed from The Diagnostic and Statistical Manual of Mental Disorders, a manual that mental health professionals use to make psychiatric diagnoses.

Additionally, the American Academy of Child and Adolescent Psychiatry published Practice Parameters on Gay, Lesbian, or Bisexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents in the Journal of the American Academy of Child and Adolescent Psychiatry in 2012. In those parameters are the following principles:

1. A comprehensive diagnostic evaluation should include age-appropriate assessment of psychosexual development for all youths.
2. The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth.
3. Family dynamics pertinent to sexual orientation, gender non-conformity, and gender identity should be explored in the context of the cultural values of the youth, family, and community.
4. Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk.
5. Clinicians should aim to foster healthy psychosocial development in sexual and gender minority youth and to protect the individual's full capacity for integrated identity formation and adaptive functioning.
6. Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.
7. Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.

The Child and Adolescent Psychiatric Society of Greater Washington would like to submit this written statement for the official record to note our support of the proposed amendment. It is our belief that all children and adolescents deserve quality, evidence based treatment. We stand by the American Academy of Child and Adolescent Psychiatry's practice parameters with special attention to principle #6 that asserts that there is no evidence that sexual orientation can be changed or altered through any type of therapy and that attempts to do so may be harmful.

We believe the DC Council can exhibit exemplary leadership by strengthening the Mental Health Services Delivery Reform Act of 2001 with this amendment and ensuring its prompt enactment.

We look forward to working with the DC Council and are happy to provide additional information if needed.

Sincerely,

Rebecca Edelson, MD
President, Child and Adolescent Psychiatric Society
of Greater Washington

References:

J. Am. Acad. Child Adolesc. Psychiatry, 2012;51(9):957-974.

November CME Dinner: *Update on the Treatment of Mood Disorders and Psychosis* Featuring Dr. Adelaide Robb

Martine Solages, MD

Adelaide Robb, CAPGSW member and incoming Assembly Delegate was the featured speaker at the first CAPSGW CME dinner event of 2014-2015. Dr. Robb is the Chair of Psychology and Behavioral Health at Children's National Health System, a renowned expert in pediatric psychopharmacology, and a highly sought-out speaker on the topic both nationally and internationally. Our members were grateful for the opportunity to benefit from Dr. Robb's expertise in a venue close to home, Maggiano's in Chevy Chase. Over a family-style Italian meal, 67 attendees were able hear Dr. Robb's update on the treatment of Mood and Anxiety Disorders and Psychosis. Dr. Robb reviewed some of the latest and most pertinent clinical trial findings. She made a point to present data from a variety of sources, including industry trials and NIH/government funded trials and she also noted the importance of reviewing the results of failed psychopharmacology trials, as they often contain insights that prompt further research or change clinical practice.

Highlights of the talk included information about the FDA approval of Duloxetine for treatment of pediatric generalized anxiety disorder and discussion of the TEAM (Treatment of Early Onset Mania) trial which compared the efficacy of Risperidone, Lithium, and Valproate in medication-naïve adolescents with bipolar disorder. In that study, Risperidone significantly outperformed both Valproate and Lithium (which had roughly equal efficacy). Dr. Robb also helped the attendees scrutinize available data on a number other topics including: the use of Lamotrigine as an adjunctive treatment for bipolar disorder, the use of stimulants in children with comorbid ADHD and bipolar disorder, the use of olanzapine and fluoxetine in combination to treat bipolar depression, and a failed trial of Asenapine in adolescents with schizophrenia. She encouraged providers to consider referring eligible patients for clinical trials, which can provide extensive evaluation and assessment as well as treatment resources. She noted that there are ongoing trails at Children's National Health System for children with Major Depression, Bipolar Depression, Bipolar Mania, and Schizophrenia.

The question and answer session that followed the presentation centered on ways to integrate the research findings into everyday clinical practice. Many in the audience commented that they had learned something that evening that would change their psychopharmacologic approach to certain clinical situations. CAPSGW extends its gratitude to Dr. Robb for her engaging talk and to the members in attendance for their enthusiastic participation. Our next CME event will be held on January 28, 2015 at Suburban Hospital and will feature Dr. David Brent who will discuss non-suicidal self-injurious behavior. ■

Dr. Solages is the CAPSGW Children's National Health System Liaison and CAPSGW Newsletter Editor.

Human Trafficking: Can You Identify If Your Patient Is A Victim?

Milangel T. Concepción Zayas, MD, MPH

Case: *J is a 16 year old female adolescent presenting to the Emergency Department. She presents with severe vaginal burning, dysuria, vaginal discharge, and genital lesions. She is in the company of a grandmotherly figure. She discloses that she was recently raped by four strangers. Upon further questioning about her family, J discloses that she has been running away from her family's home for the past several months. J reports a longstanding history of bullying that prompted her to drop out of school. Physical examination reveals a burn scar on her face, marked edema in the vaginal area, and some fresh vesicles that run all the way down to the anus. Laboratory investigations are significant for a positive HSV 2 culture. Urine toxicology screen is positive for marijuana. J is admitted to the adolescent medicine service for pain management and antiviral treatment. J is observed to be nervous, tearful, and withdrawn, and she complains of persistent headaches. She discloses feelings of sadness, worthlessness, and hopelessness. Her sleep is poor and she has decreased energy levels. Recently, she had an inpatient psychiatric admission secondary to suicidal ideation. The psychiatry team is called to assess her because of concerns about worsening depression and to provide recommendations for mental health treatment.*

As You Approach J's Evaluation, What Initial Diagnostic Impressions Come To Mind?

You evaluate J and she discloses a history of having unprotected sex in the past with several males in exchange for money, at the prompting of her "boyfriend." Her "boyfriend" also told her that she was "so beautiful" and that someday she will make it into modeling and earn more money. She shows you the internet site where she posts her pictures. Upon discussion of the details of the case, a colleague inquires, is this human trafficking?

What Are The Red Flags That Might Make You Inquire Further About The Possibility Of Human Trafficking?

What is human trafficking?

Human trafficking, also referred to as modern slavery, is a growing concern in the United States and a global public health problem. Human trafficking is the second most lucrative business in the world and has been recognized internationally as a human rights violation. It involves the leverage of power and coercion for the purpose of exploiting a human being. It is considered a crime and the United States has ratified and implemented the international protocols. The magnitude of human trafficking is unknown, because of the hidden populations affected by it. However some global reports can inform us about the trends.

Human trafficking poses health risks to the victims in the form of physical abuse, sexual abuse, deprivation, emotional abuse, manipulation, economic exploitation, and marginalization. Traffickers often prevent trafficked persons from receiving regular medical care. However, Trafficked persons commonly find themselves in the Emergency Room when injury or illness escalate and become life threatening.

Healthcare workers are more likely to have the first encounter with the trafficked victims; therefore it is fundamental for us to be aware of the issue and how to adequately assess suspected victims.

Although there is not a single sign that definitively indicates human trafficking and the research based-data is limited, several red flags have been identified including:

- Injuries such as contusions, cuts, burns with inconsistent explanations
- Delayed medical care
- Headaches and stomachaches
- Fatigue
- Severe untreated dental problems

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- Malnourishment
- Suicidal ideation and attempts, depression
- Anxiety
- Hostility apathy
- Drug and alcohol use,
- Untreated sexually transmitted infections
- Poor reproductive health
- Risk taking to repay debts
- Unattended injuries or infections

In child trafficking, victim identification remains a particular challenge. Child trafficking can take a variety of forms, including commercial sexual exploitation (prostitution), forced labor, and recruitment as child warriors in areas of conflict. Recruiting minors for the purpose of commercial sex even if no force, fraud, or coercion was involved is considered human trafficking and is prosecutable under the U.S. Law. When dealing with children and adolescents it is important to be aware of their behavior, inquire about abusive relationships, and explore the possibility of exposure to the commercial sex industry, especially in runaway and homeless youth. Along with ensuring confidentiality, it is important to create a nonjudgmental atmosphere, ensure that there are no language barriers, and use culturally-sensitive screening questions such as:

- *Are there recent changes in behavior, relationships, or attire?*
- *Are there unexplained absences from school, or has the student demonstrated an inability to attend on a regular basis?*
- *Is the patient chronically running away from home?*
- *Are there concerns for fearfulness, anxiety, depression, submission, or paranoia?*
- *Does the patient appear to have been deprived of food, water, sleep, medical care, or other life necessities?*
- *Does the patient carry an identification card?*
- *Does the patient have a "boyfriend" or "girlfriend" who is noticeably older?*
- *Is the patient engaging in uncharacteristically promiscuous behavior?*
- *Does the patient appear to be restricted from contacting family, friends, or his or her legal guardian?*

How many red flags where you able to identify in our patient? Which screening questions would have provided more information? Our patient had multiple red flags worrisome for human trafficking. In fact, she was a victim of domestic sex trafficking and there are other variables that we need to consider when planning for her care (while at the same time assuring her protection).

We cannot offer solutions if we are unaware of the problem. As physicians, it is fundamental that we start raising awareness and increasing our knowledge of this human rights violation occurring globally and with such devastating and adverse effects on the overall health of our children.

This article is an invitation to learn more about Child Trafficking and to get involved in prevention efforts so that if your next patient is in fact a victim of human trafficking, you will be better able to identify the problem, and start to facilitate a path to recovery.

Resources

If you suspect human trafficking or would like to learn more about child trafficking the following resources are available:

- The National Human Trafficking Resource Center has a national hotline that is available 24/7 at 1-888-373-7888. They help in identification of victims and local anti-trafficking services in your area.
- The International Organization for Migration along with the United Nations and the London School of Public Health and Hygiene have created a handbook for healthcare providers regarding the care of trafficked persons.
- The US Department of State published a Trafficking In Persons 2013 Report that includes several human trafficking fact sheets at http://www.state.gov/j/tip/rls/tiprpt/2013/index.htm
- Polaris Project: http://www.polarisproject.org/ ■

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CAPSGW Travel Award Essay: Reflections of a First-Time Attendee

William Cohen, M.D.

The first stop at AACAP's 61st Annual Meeting was registration. I picked up my AACAP tote bag and name tag with a special ribbon that read "first time attendee," which said it all. As a first year fellow, I arrived in San Diego with the mindset of a novice, impressionable and somewhat directionless. My main goal was to keep my head down and eyes and ears open, to take it all in and gain a slightly larger perspective on this profession I am joining.

I began by browsing the program schedule, which was a clear illustration of the incredible diversity in the field. The lectures, conferences and symposiums seemed to cover every corner of the biopsychosocial realm. It was exciting. There was almost always more than one event of interest occurring at the same time, making it challenging to plan my days. My week was filled with a conglomeration of basic science, clinical pearls, art, cultural awareness, meaningful conversations and lively socializing.

On my way to the meeting Tuesday morning I stopped for a coffee. After noticing my AACAP tote bag, a woman in the coffee shop began opening up to me about her children's mental health problems. She expressed serious concerns about over medicating children and suggested that all we psychiatrists do is write prescriptions. I was, in fact, on my way to a symposium titled "Beyond the Prescription Pad: Psychotherapy Interventions for Youth with Severe Mental Illness," which included wonderful case presentations and discussions by experts in several different models of psychotherapy. At the symposium I was pleased to observe how dedicated many child psychiatrists are to practicing psychotherapy.

The chair of this symposium, Dr. Mary Ahn, did highlight a recent change in the ACGME guideline for psychotherapy training during fellowship from "competency skills" to "beginning clinical skills," suggesting that there has been a trend to limit psychotherapy training in the CAP fellowship. Still, as evidenced by the meeting as a whole, psychotherapy, among many modalities, is alive and well in our scope of practice. Over the course of the week I certainly did not get the sense that there was an over emphasis on pharmacotherapy. The issue of medication use in children raised by that mother in the coffee shop has many nuances and is relative to every situation. The fact that she felt compelled to approach me on the street and open up about deeply personal issues was meaningful in itself. Perhaps the upfront openness was just the Southern California way, but she seemed, like many people, to be reaching out and saying, "We need more from you." Once again, it hit home to me that what was happening at this meeting matters a lot to people everywhere.

I was struck by how many speakers specifically referenced recent news stories about the topics they were presenting. I caught at least three references to separate New York Times articles at just the talks I attended. Perhaps it is an obvious point that the annual meeting covered "hot topics." After all, what else would an annual meeting be for than an opportunity to catch up on the cutting edge research and to assess our roles in current events? But I had the "newbie" ribbon on my name tag and was starting to experience the meeting's relevance for myself. I was beginning to see how we were part of a national conversation.

My excitement and motivation were growing as I took it all in. But there were so many different kinds of events, I still felt directionless, like I was just bouncing between whatever caught my eye. The tabula rasa of this novice-mindset was getting cluttered by too many interesting things. One of those things, which I seemed to just happen upon, was a Clinical Perspectives program titled "Is This Student Safe to Return to School? The Child and

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Adolescent Psychiatrist's Role in Threat Assessment for Students at Risk for Violence." This included various presentations on assessing risk for violence in schools, consulting with schools where violence occurred and interacting with the media after such disasters. There were also breakout groups where we discussed a particular case of a teenage boy who made homicidal threats.

As I was listening to the introduction something inside of me started to stir. Someone mentioned the events of Columbine High School in 1999, and I started to think about how this event was when much of my interest in child and adolescent psychiatry began. I was in high school and I remember how upsetting it was to me. I read everything I could about it, I was confused about how it could happen, and I felt the need to do something about it. Now, after a long and windy road across all of the years of education and training that brought me to this point in my career, I found myself sitting in a room of dedicated professionals actually doing something about it. I was uncovering a connection with this issue that had been there hiding behind the blank-slate all along. I also began feeling a sense of belonging among colleagues.

The next morning I attended the Disaster and Trauma Issues Committee, which is responsible for education, research, training, and response to issues of disaster and trauma with children and adolescents. I felt a genuine sense of awe about this committee's charge. These were the leaders who provide counsel about how to care for the mental health of children when there are school shootings, hurricanes, Ebola outbreaks, terrorist attacks, etc. Time and again over the years whenever large disasters occurred I would have a strong impulse to drop everything and go help. But too often that impulse was stifled by circumstances or a lack of knowledge and ability to actually make a difference. This committee speaks to that impulse and I hope to have an opportunity to work with them in the future. Also, simply attending helped me re-realize that I have had a passion about disaster and trauma issues for a long time.

Just moments after leaving this meeting I saw on the news that Jaylen Fryberg, a 15 year old freshman at Marysville Pilchuck High School, walked into his school cafeteria and shot five of his friends, fatally wounding four, and then killing himself. This horrible tragedy shouts a call of duty. It is happening right now and something must be done!

There were actually many similarities between Jaylen's situation and the case we discussed in the breakouts groups during the school violence program, which yet again highlights the significance of what we were doing out there in San Diego. It terrifies me that such violence continues to occur so frequently, and I believe child and adolescent psychiatrists have a vital role in both prevention and recovery.

A fact I picked up somewhere during the week is that there are about 8,000 child and adolescent psychiatrists in the United States and about 80,000 schools. If nothing else, this certainly means we have our work cut out for us. I walked away from my first AACAP annual meeting feeling a sense of responsibility. I am grateful to CAPSGW for the travel grant that lightened the burden to go to San Diego, because it was an inspiring trip. As a first time attendee, I had the opportunity to view the community of AACAP through a beginner's eyes, taking in the breadth and diversity of the field and gaining a better perspective on what it is all about. Furthermore, something inside of me was activated, feeling motivated to get more involved and feeling a connection between what was happening at the meeting and the world at large. ■

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CAPSGW Travel Award Essay: A Reflection on Valentine Road

Kurt Brown, MD

At the annual AACAP national meeting this year, members of the Sexual Orientation and Gender Identity Issues (SOGIC) Committee presented a viewing and group discussion of Valentine Road, an HBO documentary by Marta Cunningham. The film chronicles the tragic killing of Lawrence "Larry" King, a 15 year old male and multiracial American teenager in Oxnard, California. The film also depicts the complex aftermath in his community. Larry was a friendly and extroverted teenager, but was also small for his age, and a target of verbal harassment from peers at his high school. A few weeks prior to his killing, Larry began to wear flamboyant clothing, bright makeup, and high-heeled boots to his classes. His change in physical appearance was striking and shocked not only his peers but teachers and staff at his high school. There was mixed reaction to Larry's new appearance and self-expression, and many teachers, parents, and staff at the school did not support him. Larry began to openly flirt with males at his school; moreover, he became particularly interested in one of his classmates, Brandon Mclnerney, a 14 year old student. As Valentine's Day approached in February 2008, Larry asked Brandon to be his Valentine while Brandon was playing basketball with his friends. Brandon brought a gun to the school the following day and shot Larry in his head in the school's computer lab in front of his peers. Larry died two days later in an intensive care unit. In viewing Cunningham's documentary, there are several themes which develop about this tragedy, many of which I believe have relevance for the clinical practice of child and adolescent psychiatry.

For example, it would be helpful to think about the spectrum of behaviors associated with the expression of gender and how to educate families and school communities about these behaviors to promote an atmosphere of tolerance and acceptance. Also, what are the mental health challenges that children face when they express gender identities and sexual orientations which differ from traditional views? Finally, how does a psychiatrist navigate the legal, political, and social system when advocating for children from these communities, especially when gun violence is involved? Child psychiatrists can learn how to help children, their families, schools, and communities better understand gender development by grasping these fundamental issues. At AACAP, I had the opportunity to learn how psychiatrists get involved with these issues; this essay will explore my reflections of the aforementioned themes which were raised by the documentary.

I think that most psychiatrists would agree that there is likely a broad spectrum of factors involved in gender identity and expression. Factors determining gender may include one's biological makeup, early psychological relationships and gender expectations, and intra and inter-familial culture. There is significant variability in how one expresses gender. In Larry's case, the changes in his physical appearance and later flirtatious behaviors with his peers were likely developmentally appropriate expressions of gender and/or sexual orientation. Interestingly, the film did not show Larry expressing a desire to be female, or rejection of male identity, but his appearance nonetheless may have communicated this to his community because of their expectations. The film showed that although Larry's adoptive parents were supportive and encouraging, many of his peers and school officials simply appeared unprepared to accept Larry socially. Some teachers made derogatory and judgmental statements about these behaviors. Despite the portrayal of Larry's resiliency and persistence in expressing himself in the face of these challenges, this reaction undoubtedly had a negative impact on his self-esteem, social functioning, and academic performance. With this decline in Larry's functioning, there was no indication in the film that Larry received any form of mental health support. I think this was a missed opportunity to intervene and educate persons involved in Larry's

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Valentine Road *(Continued from page 17)*

school life. Many community psychiatrists at the AACAP Annual Meeting expressed interest in having resources for patients and families about gender development. The SOGIC Committee discussed a new plan to develop a resource guide for mental health professionals to help them understand gender development and how to work with families and communities around these issues.

The film also raised questions about the mental health challenges that children face when their gender or sexual identity is different from the majority of their peers. Larry was known to be inattentive in class and at times intrusive or impulsive with teachers. Differences in gender identity and sexual orientation do not denote a mental health illness. However, it is likely that during formative years, when social acceptance from peers and other adults outside the home is so important, rejection because of one's gender expression or sexual orientation could predispose one to mental health diagnoses such as mood disorders and substance use. Moreover, what is the impact of Brandon's actions on his community? His killing of Larry was a violent and catastrophic reaction to a seemingly playful gesture. Many adults in the community seemed to support Brandon, and while not sanctioning the killing, they appeared to suggest that some violence against Larry for his flirtations was to be expected. Many adults in Larry's school surprisingly believed that Brandon was actually the one being bullied because of Larry's flirtations. I also wonder about the mental health of the aggressors in these circumstances. Why was Brandon's reaction so violent - did he have a predisposition or history of violence, did he have a history of conduct disorder or callous personality traits? How does one begin to work with a child like Brandon and with his family, if they hold these views? Suppose Brandon came to you for a mental health evaluation - how does a psychiatrist have empathy for someone who has killed an innocent teenager? I considered what Brandon's home life was like; perhaps he was bullied or the victim of violence in his home. Where did he find the weapon, and why was the weapon not locked and protected? I think that exploring these concerns might help a psychiatrist think about how to work with both victims of violence and the perpetrators.

In viewing this film, it was clear that there are many challenges in the social, legal, and educational system for children with varying gender expression. For example, there were limited guidelines in Larry's school for children with varying gender expression and limited resources to help him. The legal system, while attempting to prosecute the Brandon, faced many challenges. For example, the system had to determine whether the trial should be held in the juvenile or adult system and whether it constituted a hate crime. An area where psychiatrists might be involved is the concern for safety and violence. For example, children who are gender nonconforming appear to be at greater risk for suicidal behaviors and verbal and physical abuse as in Larry's case. Psychiatrists can educate families and schools about this and can have a role in prevention. As discussed at AACAP, there are opportunities (through the SOGIC Committee) to learn how to advocate for patients like Larry in our clinical practice.

The film was difficult to watch because of the tragic outcome, and it was hard to see some children and adults pass off violence against Larry as expected or justified because of his gender expression. It was however encouraging to see supporters in the film and also in the conference room. Many child psychiatrists appear to be interested in how gender develops and how this development can affect mental health. There are numerous opportunities to get involved in the SOGIC Committee in doing research for the gender development section of the website. There are plans to re-organize the website to make the LGBT practice parameters more easily accessible. The film inspired me to get involved in this work, and I learned at AACAP that there are many opportunities to get involved, even as a trainee. This was my first AACAP meeting, and it was exciting to meet so many people interesting in these issues. I am very grateful to the CAPSGW travel grant committee for providing me with a travel grant to attend AACAP this year and the conference was truly a rewarding experience. ■

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CAPSGW Travel Award Essay: Advancements in Translational Research

Vijayabharathi Ekambaram, MD, MPH

I believe that attending annual meetings of professional organizations potentiates my ability to learn and also significantly enhances my performance and practice. Four months ago, I started my career in child psychiatry as a first year child and adolescent psychiatry fellow at Children's National Health System. As a novice learner in this highly demanding field, I realized that it would be essential for me to keep updated with advancements in child psychiatry by becoming active in the AACAP community. I felt fortunate to receive a CAPSGW travel grant to help fund my attendance at the AACAP Annual Meeting in San Diego. As a first time attendee, I had the excellent opportunity to learn and engage in various programs and events. I was particularly fascinated by the cutting edge translational research that was presented at the meeting.

It is always an enthralling experience to learn about the rapid advancements in translational research. The most challenging task is the efficient application of these updates in our day-to-day clinical practice. I was able to hear about the opportunities for interrupting intergenerational mechanisms of causation in child psychopathology at AACAP Irving Philips Awardee Dr. John N. Constantino's Honors Presentation entitled, "Seizing the day: An Intergenerational Structure for Higher Impact Prevention in Child and Adolescent Psychiatry." Dr. Constantino noted that, historically, behavioral genetic research concluded that environmental influences were non-shared, but that more recent theoretical and meta-analytic works have challenged this conclusion. "Shared environmental influences" are features of a person's environment that are essentially shared with other children in the family. A few examples of shared environmental influences include a parent's values/attitudes, the number of books in the house, the quality and quantity of food in the kitchen, a family's neighborhood, and the socio-economic status of the family. Whereas "non shared environmental influences" are any aspects of the environment and experiences that can be different for children within the same family (such as birth order, teachers at school, or differential treatment by parents). Dr. Constantino argued that shared environmental influences are a key source of variability in child and adolescent psychopathology. The risk and protective factors act as moderators of genetic influence (i.e. gene-environment interactions) in child psychopathology.

For example, genetic, family, and community environmental effects on drug abuse in adolescence were discussed. Dr. Constantino pointed out that the findings from a twin study (Kendler et al.) investigating the genetic and environment risk factors in the etiology of drug abuse showed that risk for drug abuse was predicted both by family socioeconomic status and neighborhood social deprivation. After controlling for family socioeconomic status, each year of living in a high social deprivation neighborhood increased the risk for drug abuse by 2%. The authors also found that a substantial proportion of the shared environmental effect on drug abuse comes from community-wide rather than household-level influences. The COGA (Collaborative Study on Genetics of Alcoholism) study findings showed a complex interplay of the *GABRA2* gene with social factors. The study reported that family support - even in families that have a history of alcohol dependence - decreases the power of genetic predisposition to alcohol abuse and a history of childhood deprivation may trigger the genetic tendency for alcohol abuse. Dr. Constantino also discussed the impact of early intervention on childhood psychopathology. The Incredible Years intervention study (Presnall et al.) for conduct disorder in children with family psychiatric histories of antisocial behavior found that Incredible Years intervention equally benefitted children with conduct disorder regardless of whether there was a family psychiatric history of externalizing behavior. In addition, a systematic review (Siegenthaler et al.) of the effectiveness of interventions to prevent mental disorders or psychological symptoms in the offspring of parents with mental illness demonstrated that, in a group of 161 individuals newly diagnosed with mental illness, interventions decreased the risk in the offspring from developing same mental illness as the parents by 40%. The children's symptom scores for both externalizing symptoms (hyperactivity, aggression, behavior problems) and

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Translational Research *(Continued from page 19)*

internalizing symptoms (depression, anxiety, negative emotions in newborns) were also lowered in the intervention groups. These findings suggest that interventions to prevent mental disorders and psychological symptoms in the offspring of parents with mental disorders appear to be effective.

The importance of gene-environment interactions in child psychopathology was further explored in the poster session. The poster titled "Gene-Environment Interaction in Youth Depression: Replication of the 5- HTTLPR Moderation in a Diverse Setting" examined the relationship between childhood maltreatment and a subsequent depressive episode diagnosis, which may be moderated by 5-HTTLPR genotypes in a large birth cohort. The results showed that there was a differential dose-response relationship between childhood maltreatment and major depressive disorder according to the 5-HTTLPR genotype. The lecture and poster presentation clearly underscore the role of gene-environment interaction in the etiology of childhood psychopathology. I took away an awareness that there are opportunities to integrate research on gene-environment interactions into our clinical practice as well as an appreciation for taking a trans-generational approach to prevention.

Apart from attending presentations and poster sessions, I was part of the AACAP monitoring program through which I was able to monitor as well as able to engage actively in various session activities. I also had an excellent opportunity to attend psychotherapy committee meeting, at the encouragement of child psychiatrist and fellow CAPSGW member Dr.Rachel Ritvo. This helped me to gain knowledge about various opportunities and resources provided by the committee for resident learning. I would like to point out that my experiences at AACAP made an ever-lasting impression in my career. I would like to thank CAPSGW Executive Committee for selecting me as a recipient of the Travel Grant 2014 and for supporting my travel to San Diego. ■

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CME Calendar of Events

January 28, 2015
Dr. David Brent
Non-Suicidal Self-Injury
Suburban Hospital, Bethesda, MD
6:00 pm Registration and Dinner, 7:00 pm Speaker

Saturday, March 7, 2015
Spring Symposium: *Addictions and the Adolescent Brain*
Suburban Hospital, Bethesda, MD; 8:00 am—4:00 pm
Up to 6.5 CME and CEU Credits (Pending)

April 15, 2015
Child Custody Dinner Salon (Members Only)
Lee Haller, MD and Christine Sorel, Esq.
Rockville, MD

May 6, 2015
International Psychiatry
Aramjit Joshi, MD
Columbia Country Club

For Registration and Information Email
capsgw@verizon.net

Welcome New CAPSGW Members

Kurt Brown
Jang Cho
Milangel Concepcion Zayas
Vijayabharathi Ekambaram
Diana Mata
Gabrielle Morosoff
Mohammad Rafiq
Haniya Raza
Michael Stachniak

A Piece of CAPSGW History: The Origin and Evolution of CAPSGW Scientific Meetings

Richard Gross, MD

While attending the November CAPSGW Scientific Meeting, I got to thinking about the "scientific meetings" that existed when CAPSGW (then the Washington Council of Child Psychiatry) re-organized after clinicians were invited into AACAP (then AACP) in 1970. Regional organizations began and organized into the Assembly of AACP. In the Washington D.C. area, at the home of Dr. Steven Maurat, the Washington Council of Child Psychiatry was formed; Dr. Maurat became the first president. My limited memory of those in attendance in addition to myself (because there are no known notes or minutes of that initial meeting), were: Drs. Steven Maurat, William Clotworthy, Larry Silver, Leon Cytryn, James Hatleberg, and Robert Sullivan. 40 other child psychiatrists joined the group and became members of The Assembly of AACAP in 1972.

With that historical explanation for reference, I will get back to those "scientific meetings" which occurred twice a year. They were usually held at what was then called Bethesda Navy Hospital in a room donated because one of us, perhaps Dr. Maurat, had a contact there. For about 20 years these were usually clinical case conferences and discussions of the case by an invited discussant who broadened the discussion with questions and answers. Cases were chosen either because of their professional difficulty or their mutually interesting subject matter. Refreshments, usually coffee and cookies, were brought by my wife, Carol, or by Dr. Virginia Powell. Years later, nationally known leaders in the field of child psychiatry would be invited to speak. Meetings were held in private rooms of local restaurants. Presentations were followed by a period of questions and discussion. Group attendance increased; one was able to know everyone in the organization in those early days as colleagues, as supervisors and supervisees. Now that we are an organization of 250 plus members, that is no longer possible. By necessity, the meetings now are more formal, much more biological, and more scientific. I do miss and ponder the loss of the clinical case conferences which engaged everyone in discussing interesting or difficult clinical problems. I wonder if this is the result, at least in part, of there being less psychotherapy done by child and adolescent psychiatrists and more psychopharmacology being utilized. We seem to be losing parts of the bio-psycho-social model, especially the psycho-social parts. Also, we seem to be losing the intimate connections between schools, education, learning difficulties and emotional disorders.

In conclusion, I pose a question. As our specialty rightfully becomes more "scientific," do we need to lose those parts of our expertise that help us see the whole child and family? Only child and adolescent psychiatrists can merge science/biology with the psyche and society. ■

Dr. Richard Gross, MD is a Founding Member of CAPSGW.

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National Institute of Mental Health
Division of Intramural Research Programs
NIMH Pediatric Clinical Research Studies
http://www.nimh.nih.gov/labs-at-nimh/join-a-study/children/index.shtml
301-496-5645 (TTY 1-866-411 1010)
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The National Institute of Mental Health (NIMH) is one of the world's foremost mental health scientific organizations. The intramural program is the internal research division of NIMH, with most of the research conducted at the National Institutes of Health (NIH) Clinical Center. The Clinical Center is the world's largest research hospital, and is located in Bethesda, Maryland, just outside Washington, D.C.

Leading physicians and scientists investigate the diagnosis, treatment and prevention of mental illness. The intramural research program is made up of different departments, each of which specializes in specific areas such as schizophrenia, depression, bipolar disorder (manic-depression), anxiety disorders, hormone-related mood disorders, childhood psychiatric disorders, and others.

NIMH intramural researchers conduct adult and pediatric research and some studies enroll eligible participants from across the United States. There is no cost to participate and compensation is available for some studies. Travel and transportation may be reimbursed for participants in some studies.

To see all NIMH research studies recruiting children, visit our website: http://www.nimh.nih.gov/labs-at-nimh/join-a-study/children/index.shtml

301-496-5645 (TTY 1-866-411-1010) nimhcore@mail.nih.gov.

Research Studies at Children's National Medical Center

Dr. Adelaide Robb and a team of psychiatrists and psychologists at Children's National Health System are conducting research studies with children and adolescents ages 7-17. Studies include treatments for depression for ages 12-17, schizophrenia ages 12-17, and bipolar disorder ages 10-17. All study-related treatments and evaluation are FREE. Patient privacy and confidentiality is assured, and families may receive compensation for time and travel while participating. Please have patients contact Lyndsey Keyte or Krista Engle at (202) 476-6067.