

May 2022 Edition

Goodness of AACAP and Goodness of Being a CAP: Learning From Leaders to Enhance One's Career

Clarice Kestenbaum, M.D.; Tami Benton, M.D.; Cynthia Pfeffer, M.D.;
Rama Rao Gogineni, M.D.; John Sargent, M.D.; David Kaye, M.D.



Clarice Kestenbaum, MD



Tami D. Benton, MD



Cynthia Pfeffer, MD



Rama Rao Gogineni, MD

This session at AACAP was targeted at ECPs and the up-and-coming generation of new child psychiatrists. The structure of the session emphasized the importance of the narratives of professionals in the field in helping to shape one's career. We heard from some of the greats—learning what made them choose child psychiatry, what shaped their trajectory, how they feel now after dedicating their lives to helping children and adolescents and what role the Academy played in their careers. The session was narrated by our very own Dr. Rama Gogineni who did a wonderful job tying the narratives together and sharing his own pearls. If you were unsure you wanted to be a child psychiatrist before this session, your commitment was likely confirmed afterwards.

Clarice Kestenbaum, M.D. shared her transition from music to medicine, her training in Israel and how difficult it was as a woman in the late 1950's in medicine. She joined AACAP when it was still AACP

(adolescent was included later); the organization consisted of about one hundred mostly White men, and membership was by invitation only. Dr. Kestenbaum chaired the program committee with Dr. Virginia Quinn Bausch Anthony, and both shared how much fun can be had in AACAP with resident poets, rock stars (Pink Floyd), cartoonists, etc. The take away was that child and adolescent psychiatry is the one medical specialty where everyone can make a breakthrough every day in the field, so there's room for greatness for all.

Dr. Pfeffer was unable to join live, but submitted her slides and her story which were presented by Dr. Gogineni. Dr. Pfeffer was taught early on that children did not have the brain maturity to commit suicide. She didn't agree with this teaching and dedicated her career's work toward understanding the suicidal child. Dr. Pfeffer changed her career work from inpatient to outpatient work to focus on the long-term follow up of suicidal children as hospital stays became much shorter. The 9/11 tragedy led to another shift in examining the long-term follow up of childhood trauma. Her message to the group was to be inquisitive and specialize or focus on a specific phenomenon; develop a longitudinal perspective in treating patients or conducting research; incorporate new and relevant issues for study; disseminate knowledge by lecturing, publishing and discussion; collaborate with and mentor others; take good care of yourselves and experience satisfaction in your work.

Dr. Sargent acknowledged his life was shaped by White male privilege, but was influenced by the civil rights movement, feminism and the Vietnam war. He shared how his early pediatric work and personal life experiences, along with his frustration with systems and poor developmental outcomes, made him interested in family work early on in his career. Dr. Sargent's life work has been committed to the best possible developmental outcome in any given situation. He opined that "Yes" and "No" are the two most important words in any language. "Yes" creates connection and "no" creates boundaries; both are important in establishing healthy relationships. Dr. Sargent learned that he must always be a student if he's to be an effective teacher, which includes a willingness to understand the cultures of those with whom he works. This has been critical in his international work where he teaches others to embrace the family as a vehicle for healing. Dr. Sargent has presented at the Academy 34 years in a row, which has allowed him to get to know his colleagues, join committees and develop lifelong friendships.

Tami Benton, M.D. knew there were two things she did not want to do in life—work with children or work in mental health—yet here she is. Child psychiatry was her first rotation in medical school. She fell in love with the field and under Dr. Elizabeth Weller's tutelage she learned the foundations of child psychiatry that support her practice today. Dr. Benton completed a triple board program at Einstein and later worked with Dr. Mina Dulcan at Children's, another great mentor. She noticed there were very few Black people in the Academy and was overheard at a meeting by Dr. Virginia Anthony commenting as such. Dr. Anthony told her "if you don't like the way the Academy looks, then do something about it." Dr. Benton joined the membership committee as well as other councils,

committees and ad hoc committees. These opportunities taught her to be a better child psychiatrist and a better leader. Dr. Benton's pearls of wisdom included: you have to know when the right time is to step into a new role; people aren't always born leaders and certainly not perfect leaders; it's ok to make mistakes; it's really about the capacity to improve yourself; developing as a leader requires you develop your confidence; it's important that you be true to yourself and embrace your uniqueness; leadership is ultimately about everyone else, not yourself. Being a woman, Black and a psychiatrist in a children's hospital are unique characteristics in her journey. Dr. Benton has had to find her voice and create a place at the table, even when others saw her role as marginalized. She lamented that sometimes you have to stand on your own in taking an unpopular position, and this was certainly true as she led her institution in its DEI work following the murder of George Floyd.

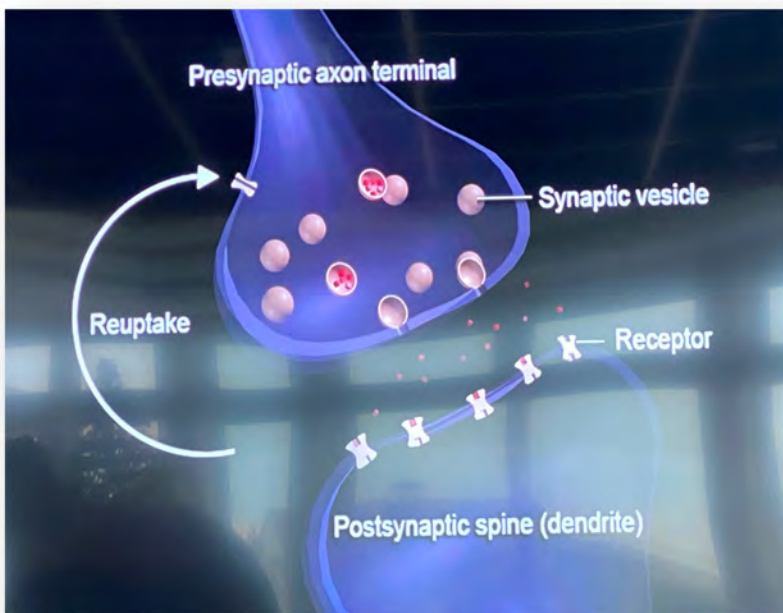
My take-aways from the session likely resonated with every medical student, resident, fellow and early career psychiatrist:

1. You don't hear child and adolescent psychiatrists (CAPs) talking about burnout.
2. Not a day goes by where these CAPs are not excited to go to work.
3. It's not work when you look forward to it every day.
4. Even into your 90s, it's still a great career (Dr. Kestenbaum).



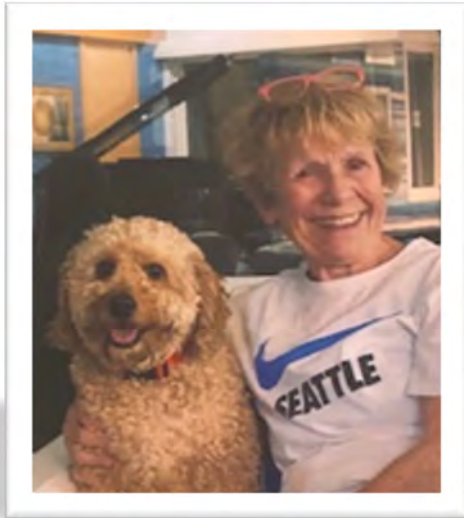
Summary by:
Yolanda Graham, MD
Secretary, RCCAP

NEUROSCIENCE



Synapse

Charles Scott Sherrington is the first person who described the junction where 2 Neuron Communicate. Prior to his proposition (1891), everyone thought the Neuron's course was uninterrupted. Sherrington noticed that nerves were conducting much faster in the spinal cord than in the brain. He concluded there must be multiple connections between nerves in the brain that slows that process down. He eventually named it "synapse" for the Greek word "to clasp".



Why should we be interested in Callous-Unemotional Traits (limited prosocial emotions) in youth?

By: Ellen H. Sholevar MD

The problem:

Some young children lack empathy, may be cruel, show less emotional expression than most, and don't seem to want to do well. They may not seem to be guilty after harming others. As an example, one young child seen clinically, deliberately jumped up and down on the legs of his puppy- crushing them- and did not seem concerned or show remorse afterwards. These children may meet diagnostic criteria for ODD or CD, but also have the characteristics noted above. They may have high or low levels of these characteristics and many meet criteria for ADHD. These children and adolescents are at high risk for a variety of adverse outcomes.

The Questions:

What do we know about the etiology? Are there multiple causes? What is effective treatment for CU traits? What are the outcomes for youth with high levels of CU traits who continue their behaviors into adulthood? What are the public health and societal issues? How stable are CU traits?

There is a good deal of research interest in these questions. Some of these young children, may – with or without treatment- continue to show the same characteristics thru middle childhood, adolescence, and adulthood. We don't have data to indicate which children will be likely to have a life course devastating to themselves, their families, to society and to be costly in every sense of that word or that the early behaviors and characteristics will desist.

What are the answers based on what we know in 2022 (the science is admittedly limited)

Q2. What is the etiology?

1. Genetic predisposition- families may show many members with lack of empathy, lack of emotional expression, risk taking behavior, cruelty to others. Children in such families may have both a genetic predisposition and trauma, as well as adults who model similar behaviors. In some studies, genetic influences are as high as 76%. Environmental trauma may also be causative. (Viding & McCory, 2012; Waller & Wagner, 2019; Takahashi, 2021).
2. Unknown causes- children who come from stable and caring families who lack empathy, are cruel, and lack motivation
3. Brain and genetic research findings- lack of response to fearful faces, comfort with risk taking, poor response to discipline (Dotterer et al, 2019; Waller & Wagner, 2019). Brain regions

implicated include the “central nucleus of the amygdala” and interconnections between corticolimbic regions. Other studies show decreased gray matter in limbic and paralimbic structures in teens with CU traits (Caldwell et al 2019).

4. Many have ADHD, intellectual ability may vary widely, some may have concurrent depression, anxiety

How stable are CU traits? The research is limited but there is a suggestion that there is stability in these traits even in very young children (Waller & Hyde, 2017). In teens, other personality characteristics may mimic CU traits and then desist. Does psychopathy in adults desist? As adults meeting criteria for psychopathy age, they are less likely to engage in antisocial and impulsive acts, but the core personality features remain throughout the lifespan (Harpur & Hare, 1994).

What are effective treatments?

1. For early childhood, Parent Child Interaction Therapy. PCIT is an evidence-based therapy originally developed by Dr. Shelia Eyberg, modified to address CU traits (Kimonis, 2014) in which a parent interacts with a young child ages 2-7 years, while a therapist observes and coaches the parent. This intervention has been shown to reduce CU traits in young children. PCIT-ED (Donahue, et al 2021) for preschool depression and conduct problems has also been shown to be helpful.
2. For youth with ADHD, medications for ADHD may be helpful. Stimulant and non-stimulant ADHD medications may reduce impulsivity and help the child to be more responsive to therapy.
3. For children in families with antisocial and cruel behavior modeled and demonstrated by adults, the family issues must be addressed, and Trauma Focused Cognitive Behavioral Therapy may be utilized. If the child is in danger, authorities may need to be notified to assess for abuse and safety.
4. For older teens with CU traits and severe aggressive behaviors in juvenile detention, the Today/Tomorrow program at the Mendota Juvenile Treatment Center in Wisconsin has been found to be helpful (Caldwell et al, 2006, 2007). The Center is on the grounds of a state hospital and staffed by employees of the hospital, not of the Department of Corrections. Teens “earn privileges following relatively short periods of positive behavior.” The points earned each day apply to privileges the next day (Today/Tomorrow). Staffing provides a variety of other therapeutic interventions and staffing levels include more psychologists, psychiatrists, and social workers than is typical in juvenile detention centers. It was concluded that, for benefit, the therapeutic interventions needed to be intense and of long duration (45 weeks). Violent recidivism in a 4 year follow-up was predicted by final behavioral scores and indicated treatment progress.
5. More information and effective treatments are needed at every stage of child and adolescent development for youth with CU traits. More longitudinal outcome studies are needed to better predict youth outcomes.

What happens to teens who continue to show high levels of CU traits?

1. Many teens with high levels of CU traits break the law and are involved in the juvenile justice system. There is little effort in most states of the US to characterize those teens who show CU traits from teens who break the law for a variety of different reasons. Wolfgang et al (1972) found that a small number of boys out of 10,000 were responsible for 70% of all murders, rapes, and assaults. In 1990, Wolfgang and colleagues, reported a similar finding; 7% of offenders were responsible for 60% of murders, 75% of rapes, and 65% of aggravated assaults. It is likely that within the group who committed the most serious crimes studied by Wolfgang, there are many with high levels of CU traits.
2. What are the public health and societal issues? The cost to society can be measured in terms of human suffering, loss of human potential, costs to the health system for treatment, and the criminal justice system for arrest, trials, and incarceration. Studies reveal that crime tends to concentrate in some families. The data from the National Longitudinal Study of Adolescent Health (Beaver, 2013) revealed that 5% of families accounted for more than 50% of criminal arrests.

What happens to youth who meet criteria for psychopathy in adult life?

1. If the teen with high levels of CU traits continues to meet the same criteria in adult life, they may meet criteria for psychopathy, now listed in DSM 5 (Hare, date; DSM 5 APA). Depending on how psychopathy is defined, the prevalence in the adult populations varies between 4.5% to 1.2% (Sanz-Garcia, et al, 2021). Adults with psychopathy contribute disproportionately to violent crime and homicide, are incarcerated at an elevated rate, and have criminal careers that are longer than most who are convicted of crimes. The cost to society in terms of human suffering is extreme and support groups of victims of adults with psychopathy can be found on the web. The economic cost of crime by incarcerated adolescents with psychopathic features greater than \$700 million (Delisi et al. 2017).
2. As pointed out by Di Brito et al (2021), this major public health problem has not been prioritized by the federal government as a priority for research investment or even mentioned as an important issue. If, as seems likely, some young children show the early characteristics of CU traits, it would seem wise to focus research and treatment interventions on this group to try to understand and treat children at risk early in life, as well as develop more effective interventions for older youth and adults.

Conclusions: As child/adolescent psychiatrists and advocates for youth mental health, we need to stay informed on the current research on youth with callous-unemotional traits (limited pro-social emotions), to recommend evidence based treatments for them, and to be advocates for increased emphasis on research and funding for youth with this serious disorder.

References:

1. Beaver, 2013: "The Familial Concentration and Transmission of Crime," *Criminal Justice and Behavior*, Vol 40, No 2, 139-155
2. Caldwell et al, 2006: "Are Violent Delinquents Worth Treating?" *Journal of Research in Crime and Delinquency*, Vol 43, #2, 148-168
3. Caldwell et al, 2007: "Evidence of Treatment Progress and Therapeutic Outcomes among Adolescents with Psychopathic Features," *Criminal Justice and Behavior*, Vol 34 #5, 573-587
4. Caldwell, et al, 2019," The structural brain correlates of callous-unemotional traits in incarcerated male adolescents," *Neuroimage: Clinical*, 22, 101703
5. De Brito et al, 2021: "Psychopathy," *Nature Reviews*, Vol 49, #7, 1-21
6. Dilisi et al., 2017: "Psychopathic costs: A monetization study of the fiscal toll of psychopathy features of institutionalized delinquents," *J Criminal Psychology*, Vol 8 #2, DOI:10.1109/JCP-07-2017-0031
7. Dotterer et al, 2019: "Antisocial behavior with callous-unemotional traits is associated with widespread disruptions to white matter structural connectivity among low-income, urban males," *Neuroimage: Clinical*, Vol 23, 101836
8. Donahue, et al 2021: "Callous-Unemotional Traits as an Intervention Target and Moderator of Parent-Child Interactionm Therapy-Emotion Development Treatment for Preschool Depression and Conduct Problems," *J Am Acad of Child & Adolescent Psychiatry*, Vol 60, #11
9. Hare & Neumann: "Psychopathy: assessment and forensic implications." *Can J Psychiatry*, Vol 54, 791-802
10. Harpur & Hare, 1994: "Assessment of psychopathy as a function of age," *J Abnormal Psychol*, Vol 103, #4, 604-609
11. Kimonis, 2014: "Parent training outcomes among young children with callous-unemotional conduct problems with or at risk for developmental delay," *Journal of Child & Family Studies*, Vol 23 #2, 437-448
12. Sanz-Garcia, et al, 2021: "Prevalence of Psychopathy in the General Adult Population: A Systematic Review and Meta-Analysis, *Frontiers in Psychology*, 12, 661044
13. Takahashi et al., 2021: "Genetic and environmental influences on the developmental trajectory of callous-unemotional traits from childhood to adolescence," *J Child Psychology & Psychiatry*, Vol 62, #4, 414-423
14. Viding & McCorry, 2012: "Genetic and neurocognitive contributions to the development of psychopathy," *Development and Psychopathology*, Vol 24, 969-983
15. Waller &Wagner, 2019: "The sensitivity to threat and affiliative reward (STAR) model and the development of callous-unemotional traits," *Neuroscience and Biobehavioral Reviews*, Vol 107, 656-671
16. Wolfgang et al, 1972: *Delinquency in a birth cohort*. Chicago. University of Chicago press

BIPOLAR DISORDERS IN YOUTH

NEW FINDINGS ON BIOMARKERS, ILLNESS COURSE AND TREATMENT



David J. Miklowitz, PhD
University of California in LA, et al.



Melissa P. DelBello, MD, MS
University of Cincinnati



Benjamin Goldstein, MD, PhD,
Center for Addiction and Mental Health

This symposium reviewed the new findings on:

- I. A) Psychosocial intervention in modifying mood symptoms in high risk youth; B) neural mechanism by which treatment may modify illness course among high risk youth; and, C) neural and immunological markers and bipolar disorder (BD), high risk.

II. **Psychological Intervention with Bipolar Youth**

David Miklowitz from the University of California in Los Angeles, and his co-workers are the current pioneers of the distinguished investigators at UCLA who have extended the impressive work of this group on family interactions and has blended it with advances in biological psychiatric research with severe mental illness. The group has expanded on their previous findings that there are recognizable risk factors for the onset of bipolar disorder (BD), in children and adolescents with a family history of BD manifested by: Depression, hypomania, mood instability and anxiety. In high-risk youth defined by this criteria, they examined whether family-focused treatment (FFT) was more effective than standard psychoeducation in reducing the rate of mood disorder episodes and suicidal thinking/behavior with a follow up of 1-4 years. They found that youth in FFT did not differ from those receiving standard psychoeducation on the length of time to recovery from their index symptoms. However, youths in FFT had longer periods between recovery and emergence of the next mood disorder episode, and between randomization and next mood episode, compared to youth in standard psychoeducation. Youth in both conditions showed improvement in symptoms severity over time, although distinct course patterns were observed over 1-4 years of follow up. Youth in FFT had lower levels of suicidal thinking and behavior than youth in the comparison conditions. The investigators concluded that FFT appears to be an effective early intervention for youth at high risk for BD, especially for preventing new onset

depressive episodes. Treatment appears to be most effective when levels of family conflicts are reduced. There is considerable heterogeneity in the course of mood symptoms in high-risk youth, and treatment may need to be reinforced in booster sessions to have long-term effects.

Family-focused therapy (FTT) as an early intervention has been used in a number of studies with adults. It is time-limited (12 sessions over 4 months) and begins with diagnostic assessment (KSADS-PL). Three treatment component modules include:

- Psychoeducation about bipolar disorder.
(symptoms, early recognition, etiology, treatment, self-management).
- Communication skills training.
(behavioral rehearsal of effective speaking and listening strategies).
- Problem-solving skills training.

In the present study, the effectiveness of FTT versus duration-matched enhanced care has been studied in three sites, including 127 patients with a mean age of 13.2 (range 9-17). It has included the person with BD or other specified BD person, plus relatives with BD-1 or 2. Family intervention has reduced the intensity of the symptoms by more than 50% by 20 weeks. The gain has been sustained, or slightly enhanced, following that period.

Active mood symptoms were measured on YMRS (scores over 11), or on CDRS-R (scores over 29). 65% of the samples were female, 18% racial minority and 17% Hispanic. Lifetime co-morbidity of anxiety disorders was 58%; ADHD was 36%; Disruptive Behavior Disorder was 21%.

Treatment and follow up included:

- 12 FTT sessions versus 6 family and individual psychoeducation (EC) sessions, both lasting for 4 months.
- A standardized pharmacological algorithm.
- 2-4 year follow up (median 98 weeks).
- Pre and post treatment neuroimaging.

Communication skills training include: to look at the other person while making a request; say exactly what you would like the other person to do; tell the other person how it would make you feel. Use phrases such as “I would like you to...”, “I would really appreciate if you would do...”, “It’s very important to me that you help me with the...”

III. **Melissa DelBello, MD: Limbic Microstructure and Connectivity in Youth at Risk for Bipolar Disorder (BP)**

Dr. DelBello uses diffusion tensor imaging (DTI) and resting state functions of connectivity (RSFC) to compare limbic microstructure and connectivity among youth with ADHD with or without a family history of BD, high

risk (HR) and low risk (LR) and a healthy comparison group. She has found significant fractional anisotropy (FA) differences in bilateral insular cortex, and right cuneus, and mean diffusivity (MD) differences in the left anterior frontal gyrus. HR youth exhibit increased FA in the bilateral insular and the left superior and inferior temporal cortex, and increased MD in the right amygdala, bilateral inferior frontal gyri, and right medial frontal gyrus. RSFC analysis reveals that the HR exhibits greater right amygdala to right ventrolateral prefrontal cortex (R-VLPFC) connectivity compared with both HR ($P < 0.0001$) and LR ($P = 0.017$) youth.

Conclusion: altered microstructure in the dorsal stratum was present in youth with ADHD and not in youth with attention deficit who are at risk for developing BD. Right amygdala-VLPFC resting state hyperconnectivity distinguished youth for BD and may represent a prodromal risk biomarker for bipolar disorders.

IV. Benjamin Goldstein, MD, PhD: Inflammatory Markers and Brain-Driven Neuroleptic Factors in Adolescent Bipolar Disorders

Dr. Goldstein had studied inflammatory markers, Brain Driven Neuroleptic Factor (BDNF) and the Symptomatic Course of Adolescent Bipolar Disorder in a Prospective, Repeated Measures Study.

Numerous studies have found elevated proinflammatory marker (PIMs) and reduced brain-driven neurotrophic factor (BDNF) during symptomatic episode of bipolar disorder (BD) in adults. Goldstein has remedied the paucity of the research examining these markers in youth with BD, or longitudinally in any BD subgroup. He has concluded that in the first repeated measured study on this topic in adolescents with BD, there were evidence that CRP, and inexpensive and ubiquitous blood tests, may be useful in predicting the prospective course of BD symptoms. During the most severe symptomatic intervals among adolescents with BD, levels of CRP and Pro-to-anti-inflammatory ratios were significantly greater and IL10 levels were significantly lower, vs Healthy Controls (HC).

CONCLUSION:

CPR, AN INEXPENSIVE AND UBIQUITOUS CLINICAL MARKER HAS THE POTENTIAL TO INFORM PREDICTION OF THE FUTURE PROSPECTIVE COURSE OF BD.



IN THE NEXT ISSUE:

**SEX TRAFFICKING BY YOLANDA GRAHAM, MD
SECRETARY OF RCCAP AND DISCUSSION BY MULTIPLE
SENIOR CHILD AND ADOLESCENTS PSYCHIATRISTS.**



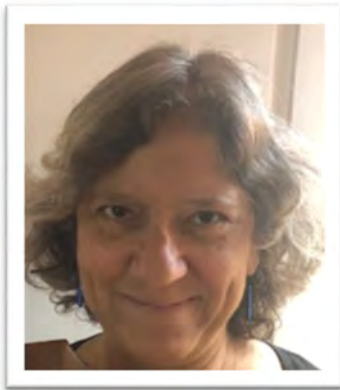
**G. Pirooz Sholevar, MD
Editor**

Conference Summary:

10th Child and Adolescent Psychotherapy and Psychopharmacology Conference

Topic: Current Adolescent Sexual and Gender Issues

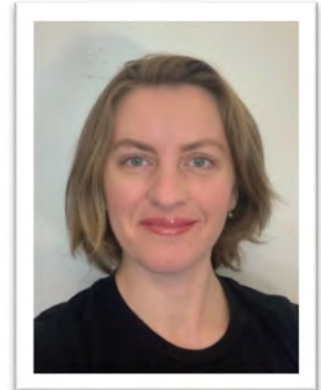
CME's



Speaker:
Annie Steinberg, MD

Developmental and Forensic Aspects of Child Sexual Abuse

Annie Steinberg, MD
Clinical Professor, Dept. of Psychiatry,
Perelman School of Medicine at the
University of Pennsylvania



Summary By:
Elena Safronova

Dr. Annie Steinberg, child and adolescent psychiatrist, she directs the child forensic psychiatry track at the University of Pennsylvania, she's also Co-directed the center support of rights of children to be safe in their homes and with their families. She gave a presentation titled "Child Sexual Abuse: Developmental and Forensic Perspectives".

Hundreds and sometimes over 1000 children have been sexually abused, sometimes with videotaped evidence of the nature of the abuse. How children manage and the different variations of their response should be recorded in *Subpoena* for production of evidence. The court may be a fact witness or an expert witness. The expert is independent, which means that no matter who has hired expert, one should do the same evaluation and write the same report. Forensic evaluations are different breed entirely from therapeutic evaluation. They can be compelled over objection of the examinee initiated by a third party there for the purpose of assisting the court in answering a legal question. Specific parameters of psychosexual evaluation often guide the formatting process more than for General mental health evaluations. Psychosexual assessment can often mean an evaluation that focuses on sexual development. Sexual history, paraphilic interests are signal adjustment, risk level or might simply address victim profile in history. They can be requested for forensic purposes or for evaluations to guide treatment.

Psychiatrist may get involved in forensic matters that involve child sexual abuse and will be asked to do psychosexual evaluation. There may be allegations about harm to a child and family, conflict or custody dispute, symptoms of concern that are exhibited when a child welfare system is involved and psychiatrist will be asked to assess the injury from potentially an act or an omission on the part of the caretaker and to identify the difference between abuse and accident. Or maybe civil litigation after alleged or documented injury and abuse to assist with the credibility or the preparation of the child witness. It could be civil litigation that is asking about what are the necessary interventions or what the level of monetary compensation should be sought for the child. It also can be a criminal child abuse proceeding which is about the accountability in the prosecution of the offender or it can be the decisions making regarding the reunification of a child following foster care placement, assessing parental capacity, potential for harm for best interest of the child.

There are two different paths in child abuse: simple and criminal path. The civil side follows state child protection laws and the focus is on the child welfare as opposed to offender accountable. The need is to prove non accidental injury caused by the caretakers act or omission, whereas in criminal it's a criminal act on a child. So there is a removal of child from parents permanently. On the civil side is preponderance of the evidence, which is more than 50% chance of what's also known as more likely than not. Whereas on the criminal side, before you convince somebody, it has to be beyond a reasonable doubt, and that means the jury has to be virtually certain. It has to be the absence of another logical explanation.

Then there are state variations in the definitions of abuse and neglect. We don't have a national data set with uniform standards. Valuable term was offered: child sexual abuse is a sexual contact with a child that's a result of force or a relationship that's exploitative as a result of age difference or caretaking responsibility.

And to what degree can retrospective findings be applied to the experiences of current generation of children? Huge range from 2 to 62% for women. For men the range is 1 to 15% for the prevalence of child sexual abuse. Effects of child sexual abuse that 67% of victims experience internalized psychosocial sequelae: sleep, eating fears, phobias, depression, guilt, shame, anger when the perpetrator was a family member and less when the perpetrator was unrelated.

Dr. Steinberg gave explicit advice: before meeting with a child, do the history and also find out about the developmental capacity, their communication mode, many sensory disabilities, intellectual academic reading level issues, and maybe a little bit about their extracurricular life. Be aware that a young child has a limited attention span. There is the concepts of who, what, where? Figure out if the child knows the difference between truth and a lie between real and pretend. In assessing the child description of the sexual activity, look for sexual knowledge beyond that expected for child developmental stage. Obviously more weight is given to free narratives and that there should be no contradictory information. Gradual disclosure is quite common, it doesn't mean that their child is inconsistent. Sources obtained can include law enforcement, forensic interviews, and multiple interviews are interested to increase the risk of taint being introduced. Defense and prosecution experts may offer opinions about how reliable a child statement might be. But they're not allowed to offer words about the child credibility that is not in the domain of the expert. The goal in the forensic

evaluation is to avoid embedded bias as it creates a distorted filter, avoid misplaced altruism, aware of motivations to save data for colleagues to review in details. Children give accurate histories but they don't disclose for lots of reasons: secrecy, loyalty, conflicts, fear of punishment and other repercussions.

As such, we as child psychiatrists have important roles to play in reporting the evaluation appropriately, as well as testifying and being prepared and willing to do so once we are involved in children who potentially have been sexually abused. The goal is to maintain emotional neutrality and being nonjudgmental. We should consider videotaping just to preserve the child. Initial statements will be reported in the psychiatrist office and we should try to offer the child reasonable protection while preserving crowd capacities and the therapeutic relationship. We have an important role to play in the evaluation of child sexual abuse and the protection of both children and parent child relationship. We are all tasked every day with having to do interviews with children who may have experienced some type of trauma. And it's oftentimes difficult to make sure that we are not leading the child down the path that we think is best for them with our own biases.



Evaluation and Treatment Considerations for Transgender and Gender Diverse Youth

Anderson Still, MD

Attending Psychiatrist, Gender and Sexuality Development Clinic,
Children’s Hospital of Philadelphia

Speaker:

Anderson Still, MD

Summary By:

Swanny X Shi

Dr. Anderson Still, attending adolescent and child psychiatrist at the Children's Hospital of Philadelphia and program psychiatrist for the Gender and Sexuality Development Clinic, gave a presentation titled “Evaluation and Treatment Considerations for Transgender and Gender Diverse Youth.”

When considering the overall topic of gender, there are multiple aspects that comprise it, including sexual anatomy, gender identity, and gender expression. Related to these topics is also sexual orientation. All of these contribute to an individual’s psychological development. It is important to ask patients who present to mental health services about gender identity and sexuality, and at the same time, important to remember to not assume relevance between these and the mental health concerns that they are presenting with. Transgender and gender diverse youth can come in because they are experience gender dysphoria or transition, and also for a variety of other mental health concerns, such as depression and anxiety. Teasing out the relationship between possible gender dysphoria and other mental health concerns as well as the overlapping symptoms between gender dysphoria and other psychiatric conditions can add to diagnostic challenge.

Dr. Still offered valuable advice for opening the discussion without over-assuming a relationship between a patient's gender identity and other mental health concerns in a general psychiatric evaluation with questions such as "Is there anything important for me to know about your gender identity or expression?" or "Do you have any concerns about the way that your gender identity affects your mental health?" The answer may be that there is not a lot of overlap between, for example, a patient's depression/anxiety and their gender identity. However, sometimes there is a significant relationship and the patient's gender dysphoria is really driving the depression/anxiety. Once a provider gains a better understanding of this, the discussion of treatment for gender dysphoria or other conditions can begin.

The approach to treatment for gender dysphoria is about being affirming and loving, and supporting patients' exploration, Dr. Still emphasized. Similarly to most children who present to psychiatric services, it is always important to consider the many environmental and social external factors that can affect patients' mental wellbeing. There are a number of specific social and environmental factors to consider in transgender, non-binary, and gender diverse youth. They are at increased risk for lack of family or social support, experience higher rates of physical, emotional, and sexual abuse, and are at increased risk of peer bullying. Suicide rates in these children and adolescents are also significantly higher. Therefore, Dr. Still explained that a lot of work in the gender clinic involves working with families to support that patient. Helping patients and their families with acceptance and support can be just as important as medical treatment.

Transitioning is the process in which an individual moves from living as their gender assigned at birth to how they see and understand themselves and is not always a linear process. As there is still much clinical research to be done on the process of transitioning, there are currently a mix of clinical guidelines from multiple organizations, such as the World Professional Association for Transgender Health (WPATH), Endocrine Society, and Center of Excellence for Transgender Health.

Dr. Still highlighted that a requirement for beginning the treatment process in all the guidelines is the diagnosis of gender dysphoria. Following that, he also emphasized the multidisciplinary approach to the initial and ongoing mental health and medical assessments involving psychiatrists, licensed social workers, psychologists, and other physicians. A thorough discussion of treatment options, their risks and benefits, and long-term outcomes with patients and their families is essential. These options can include puberty blockers, hormone therapy, and gender affirming surgery.

Until puberty, the treatment of gender dysphoria centers around the social transition, which can include choosing a name, haircuts, and clothing style. Mental health counseling can guide the patient and family through this process. Treatment options thereafter can include puberty blockers if patients present before the development of secondary sexual characteristics. Puberty blockers can be beneficial in allowing patients more time to think about their goals and discuss options going forward. In addition, delaying the development of secondary sexual characteristics can prevent the need for surgical intervention. Overall, it is important when treating transgender, non-binary, and gender diverse youths to form a supportive and accepting therapeutic alliance.



Juvenile Sex Offenders and Interventions

Speakers:

**Chioma Iheagwara, DO
& Rama Rao Gogineni, MD**

Summary By:

Aysha Rehman

Chioma Iheagwara, DO

Division Chief of Child &
Adolescent Psychiatry,

Belmont Behavioral Hospital

Rama Rao Gogineni, MD

Professor of Psychiatry,
Cooper Medical School of
Rowan University

Dr. Iheagwara and Dr. Gogineni co-presented regarding the topic of juvenile sex offenders and appropriate interventions to recommend regarding this patient population.

Dr. Iheagwara explained the typical development of sexual inclinations and gender awareness. In infancy, masturbation is not uncommon to present. From ages 2-6, children begin to become aware of their gender identity, recognizing their sexual body parts, derive pleasure from self-stimulation, and have a limited understanding of sexual activity. As they progress to ages 7-12, they gain knowledge and awareness of what masturbation, intercourse, and pregnancy are. Puberty related changes also occur during this time. They may begin engaging in sexual play with themselves or others. This awareness of their own body and experience of changes they cannot control may lead to feelings of shame, e.g. an uncontrolled erection in class. Moving on to ages 13-18, this is when children typically begin to endorse attraction to their preferred persons. An increase in self-stimulation may also occur, as well as the formulation of goals appropriate to this age group, inclusive of forming emotional closeness and intimacy with a partner.

Dr. Iheagwara then juxtaposed inappropriate and atypical, infrequent sexual behaviors in early childhood which included behaviors such as: preoccupation with sexual play, especially sexual play that makes others uncomfortable. This also included sexual activity with much younger or older youth, a precocious knowledge of sex and sexual activity beyond their age, soliciting or asking for adult sexual acts, undressing of others, touching others' genitalia after being told not to, masturbating with objects, and using bribery, threats, or force to engage others in sexual play.

Dr. Gogineni, co-presenting the topic, provided discussion regarding human sexual instincts as paraphilia or perversion. He explained that human sexual instincts can become fixated on a wide variety of targets, which may result in behaviors ranging from harmless fetishism to a severe extreme of child abuse.

The most commonly politically and socially discussed paraphilia, he explained, is pedophilia.

Dr. Iheagwara went on to explain psychopharmacological interventions previously and currently utilized in the treatment of sexual offenders, to reduce sexual drive and prevent recidivism. She explained that previously surgical castration and stereotaxic neurosurgery had been utilized, at the most extreme. Currently however, the most common pharmacological treatments include anti-androgens such as medroxyprogesterone acetate and LHRH analogues, as well as SSRIs and alpha-2 agonists, such as Guanfacine and Catapres.

She also noted that co-morbidity among this delinquent population should also be remembered, as it is the norm; these co-morbidities included mental retardation, pervasive developmental disorders, PTSD, depression, bipolar affective disorder, and attention-deficit/hyperactivity disorder. She cautioned for care use of anti-depressants for treatment of anxiety and depressive disorders in these settings, as well as mood stabilizer utilization for those diagnosed with bipolar spectrum disorders, and stimulants and atomoxetine with those who have co-morbid ADHD.

**TALKING ABOUT SEXUAL HEALTH
A TOOL FOR YOUTH WORKERS**

Talking about sex, sexuality and sexual health with young people is an important area of work for youth workers. It is not about having all the answers, but understanding young people's thoughts, concerns, challenges and strengths, and supporting them to make informed choices about their health and well-being.

Youth workers are trusted sources of sexual health information for young people. Young people want you to start the conversation:

- It's not complicated – it can be brief!
- It doesn't have to be embarrassing – it's not about you! It's about helping the young people who trust you to have these conversations.
- Don't know the answers? That's OK, you don't have to be an expert!
- Use your own language and be authentic.

Look for opportunities to start a conversation or build on what young people are already asking or talking about.

<p>PERMISSION</p> <p>Ask permission – it shows respect and helps young people feel safe.</p> <p>"Can I talk with you about relationships and sexual health?"</p> <p>"A lot of young people have questions about relationships, and sexual health – I'm always here if you need to chat."</p> <p>"Do you have anything on your mind you'd like to talk about now?"</p>	<p>OPEN THE CONVERSATION</p> <p>Find out what they already know. Let the young person lead the conversation.</p> <p>"What do you already know about...?" (e.g. sexual health/condoms/STIs/going on a date)</p> <p>"Have you seen these new resources about relationships and sexual health that we have in the centre? What did you think of them?"</p>	<p>INFORMATION</p> <p>Extend on existing knowledge and correct any misconceptions. Give the young person some relevant information to address concerns and keep the conversation going.</p> <p>"It's important to always use condoms with a new sexual partner, and to have regular sexual health checks."</p> <p>"Remember to take condoms with you when going on a date, whether or not you think you might need them."</p>	<p>CHECK IN</p> <p>Acknowledge what they have to say and check their understanding.</p> <p>"What are your thoughts about that?"</p> <p>"Do you know where you can get condoms?"</p>	<p>RESOURCES</p> <p>Provide the young person with more information and access to resources.</p> <p>"Let's have a look at some resources together. Have you seen the Play Safe website?"</p> <p>"Can I show you this video about what it's like to go to a sexual health clinic?"</p>	<p>REFERRAL</p> <p>Explore ways to address any barriers to accessing sexual health services (i.e. GPs and sexual health clinics) with the young person, and introduce them to a service that is right for them.</p> <p>"There are lots of places you can get information and help...can I show you some options?"</p> <p>"Here are some services other young people have found useful."</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

© 2018, Jessica M. and David J. ©2018 The youth workers' roles in young people's sexual health: A practice framework, Youth Sexual Australia v 20, p.4

Reference: Play Safe from NSW Health (<https://stipu.nsw.gov.au/wp-content/uploads/Talking-About-Sexual-Health-Tool.pdf>)

Henri Parens, groundbreaking psychiatrist and psychoanalyst, author, and inspirational Holocaust survivor, dies at 93

Separated from his family when he was a boy, he counseled, lectured, and wrote about relationships, especially those between children and their parents. "The ability to be empathetic" is key, he said.

by [Gary Miles](#) – The Philadelphia Inquirer

(<https://www.inquirer.com/obituaries/henri-parens-obituary-holocaust-psychiatry-jefferson-20220303.html>)

Mar 3, 2022

Henri Parens, 93, formerly of Wynnewood, a celebrated professor of psychiatry at Thomas Jefferson University, research professor of psychiatry at the Medical College of Pennsylvania, analyst at the Psychoanalytic Center of Philadelphia, prolific author, and Holocaust survivor, died Saturday, Feb. 19, of congestive heart failure at an assisted living center in Minneapolis.



"The perfect parent is perfect 70 percent of the time," Dr. Parens said in 1988. "If you love and respect the child and the child knows it, you can make a lot of mistakes" without damaging the child. LAURENCE KESTERSON / INQ KESTERSON

Dr. Parens escaped alone from a detention camp in France when he was 12, made his way to the United States at 13, and never again saw his parents, older brother, or other relatives. Motivated by his horrific experiences as a child during the Holocaust, and inspired by the bravery and selflessness of his mother, who encouraged his escape, and those who aided him along the way, he dedicated the rest of his life to helping children, parents, and others understand and manage despair, prejudice, aggression, and other destructive behavior.

As a private psychiatrist and psychoanalyst for more than 50 years, he specialized in treating children with psychological trauma and was known by many as "the father of parenting education." He lectured, held workshops, and directed research groups on family relationships and other issues around the world and served with the United Nations and other global organizations to stymie what he called the "malignant prejudice" of ethnic hatred and genocide.

As director of the infant psychiatry section at the Medical College of Pennsylvania, now the Drexel College of Medicine, Dr. Parens counseled parents to “keep telling [your children] and showing them that you love them, but give them the space they want. Don’t push too hard. They’ll make the move when they’re ready.”

Longtime Inquirer columnist Darrell Sifford followed that advice and wrote in 1988: “I’ll forever be indebted to [Dr. Parens] for his support and encouragement during the bleak times when I was struggling to reconcile with my sons after their mother and I divorced.”

He [published](#) a dozen books, including [The Development of Aggression in Early Childhood](#) in 1979, his 2004 memoir, [Renewal of Life: Healing from the Holocaust](#), and [War Is Not Inevitable: On the Psychology of War and Aggression](#) in 2014. He also wrote, edited, and contributed to nearly 300 books, articles and papers; was quoted extensively in The Inquirer and other publications; and became involved with [podcasts](#), scientific films, documentaries, a TV series, and other projects.

His six-unit textbook, [Parenting for Emotional Growth](#), first published in 1995, and accompanying materials were designed specifically to provide a curriculum for parenting education “alongside reading, writing, and arithmetic in the primary and secondary education of every child.” Versions of it have been adopted by schools in the Philadelphia area, New York, Illinois, Alaska, and elsewhere, and it’s online contents have been downloaded in nearly 100 countries.

He won many awards, including the 1993 Miriam Jones Brown World of the Child Award from Friends School Haverford, and the 2019 [Sigourney Award](#) for outstanding contributions to psychoanalysis. The Henri Parens Hope Scholarship was created in his honor by the Psychoanalytic Center of Philadelphia for students who plan to “improve the lives of individuals, especially children and the underserved.”

Referring to the Miriam Jones Brown Award, Betty-Ann Workman, then the principal at Friends School Haverford, told The Inquirer in 1993: “Dr. Parens... helps adults understand the world of the child, which has a slightly different twist to it. It is switching the gears, and I think he does this magically.”

Born Henri Pruszinowski in Lodz, Poland, in 1928, Dr. Parens lived with two families in Pittsburgh after he arrived in the United States in 1942. A singer and pianist as a young man, he earned a bachelor’s degree in music at Pittsburgh’s Carnegie Tech, now Carnegie Mellon University, in 1952.

He served two years in the Army as a medic in Germany after college, and, thinking that medicine would be more reliable than music to support the family he wanted, he obtained his medical degree at Tulane University Medical School in 1959.

He met Rachel Anto through mutual friends, and they married in 1955. They had sons Erik, Karl, and Joshua, and he completed his residency in Cincinnati before joining the Medical College of Pennsylvania as a research professor of psychiatry in 1969.

He moved to Jefferson as a professor of psychiatry in 1992 and retired in 2017. Colleagues called him “a mensch in the literal sense of the word,” and said in a tribute: “His ideas frequently provided the capstone in the arch of human understanding.”

He spoke French, accompanied himself on the piano and sang often at home. He liked to wear vests and hats indoors because he was sensitive to cold, and painstakingly named all the researchers who collaborated with him over the years when asked about his success.

His son, Erik, said: “He became an eloquent and tireless warrior for promoting the flourishing of all.”

In addition to his wife and sons, Dr. Parens is survived by eight grandchildren and other relatives.



Dr. Parens (fifth from left) enjoyed spending time with his three sons and their families.
Kasich Photography



LEHIGH VALLEY HEALTH NETWORK

Child and Adolescent Psychiatry

By: Dhana Ramasamy, MD
Child and Adolescent Psychiatrist, LVHN

May is “mental health awareness month”. It is time to raise awareness about the importance of mental health and to look more closely at mental health crisis drivers. COVID-19 has had a profound impact on nations mental health and has added to the challenges of an already troubled mental health care system. The greatest increase is in the percentage of youth who have emotional concerns and higher rates of suicidal ideation, particularly LGBTQ youth. Many factors play a major role in mental health issues, such as loneliness, isolation, including inequities in care.

Recently, AAP, CHA and AACAP jointly announced the recent mental health crises in the nation. In addition, according to AACAP workforce maps, the number of child and adolescent psychiatrists (CPAs) is 14 per 100,000 and we need more than 40. Lack of access affects our ability to care for youth, resulting in greater acuity and complexity, and increased emergency room visits. Many legislative efforts are towards these initiatives.

In these challenging times, I would like to mention about our Child and Adolescent Psychiatry (CAP) residency program at the Lehigh Valley Health Network (LVHN). Department of Psychiatry offers a two-year training in Child and Adolescent Psychiatry for selected residents who have completed at least the PGY-3 year of training and passed USMLE step 3. We are ACGME approved for 4 positions.

Our program fosters a culture of respect, diversity, fairness, inclusiveness, and professionalism. We welcome individuals from all backgrounds. We prepare fellows according to guidelines recommended by the American Academy of Child and Adolescent Psychiatry (AACAP) and by the Committee on Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology (ABPN). Our training includes assessment of a child's normal and abnormal development and treatment with pharmacological, cognitive, psychodynamic and social

approaches. All our fellows are encouraged in teaching beginners as well as in quality improvement projects. We have seminars and open discussions on diversity, culture, social determinants of health, and racial inequities.

Our patient population is diverse geographically (urban, suburban and rural), racially (White, Black, Hispanic, and other minorities including immigrants and refugees), and socioeconomically. Diverse clinical experiences are provided that span the diagnostic spectrum, ranging from children and adolescents with depression and anxiety to developmental disorders to central nervous system disorders to genetic disorders. Both Child Psychiatry and Psychology faculty provide supervision, with additional input from speech pathologists, psychiatric nurses and a multitude of other professionals.

Building on the resources of the Department of Psychiatry, the Division of Child and Adolescent Psychiatry (DCAP) offers a diverse faculty, a comprehensive didactic curriculum, and modern inpatient and outpatient clinical facilities.

Living in the Lehigh Valley has its merits, is a scenic region of eastern Pennsylvania. The traditional boundaries of the region are the Pocono Mountains to the north, the Delaware River and New Jersey to the east, the boundaries of Berks and Montgomery counties to the southwest, and the boundary with Bucks County to the south. Our patient population is diverse geographically (urban, suburban and rural), racially (White, Black, Hispanic, and other minorities including immigrants and refugees), and socioeconomically.

In summary, the objective of our residency program is to prepare clinically astute, well-rounded and culturally diverse graduates who are willing to take on leadership roles in our field. Thank you for the opportunity to discuss our program and, most importantly, we are pleased to contribute to the enriching and fascinating field of child and adolescent psychiatry!

References:

AAP, AACAP, CHA declares national emergency in children's mental health

Published: October 2021

Mental Health America. 2022. *Mental Health and COVID-19: Two Years After the Pandemic, Mental Health Concerns Continue to Increase.*

[Workforce Maps by State \(aacap.org\)](https://aacap.org/workforce-maps-by-state)

Please refer to our LVHN residency link [Residency and Fellowship Opportunities \(lvhn.org\)](https://lvhn.org/residency-and-fellowship-opportunities)

Citizen Joel Edelstein, MD

with Lizzie Edelstein, MD

Dr. Joel Edelstein has been trained in General Psychiatry, Child and Adolescent Psychiatry, Psychoanalysis, and Child Analysis at the most prestigious psychiatric departments in this city. He received his medical education at Hahnemann University, which was at the time known as one of the leading psychiatric and child psychiatric centers in the country. He, then selected Institute of Pennsylvania Hospital for General Psychiatric Training; the Institute being the first psychiatric hospital in the country established by Benjamin Rush, MD and Benjamin Franklin. He was trained in child psychiatry with Herman Belmont, MD, who was the Dean of Child and Adolescent Psychiatry in the city, and has trained most of the leading child psychiatrists in the city who dispersed throughout the country.



He undertook his general psychoanalytic training, as well as child analytic training, at Philadelphia Association for Psychoanalysis, which is one of the parent organizations for the present Center for Psychoanalysis in Philadelphia. He labored hard in this demanding training and graduated with very solid foundation, which provided the ground for becoming a post-modern psychoanalyst who could utilize the psychoanalytic knowledge and skills in other fields, including child and general psychiatry.

Dr. Edelstein has developed very strong child and adolescent psychiatric practices in the outpatient/office psychiatry, in-patient, school consultation, and most extensively in residential treatment of children and adolescents. He has further subspecialized in this practice in the past 25 years by heading a unit and a program for young adolescents and children who have been burdened by an extensive assault on their development biologically, psychologically, and psychosocially. He has gained much expertise with said children, and particularly their families, which has allowed him to provide the most comprehensive care. He has stayed with the same institution for 25 years, and has exhibited the same consistency with his private practice and school

consultation. As a result, he has a huge number of professionals who have been nourished and educated by him consistently in the past few years, and have learned to take advantage of every drop of his teaching and replicate it in their own practice with the same or similar populations. He is just the fountain and reservoir of DNA of psychiatric knowledge sitting in the psychiatric chromosome waiting for the customers to come asking for information, and he would put out a messenger RNA to allow them to construct the therapeutic interventions they need.

I have watched Joel very carefully in the past 25 years, and have known him since he was a medical student at Hahnemann to the present time that he has become a towering figure in child psychiatry. One of my greatest joys has been getting hold of his evaluations and follow ups, and read it carefully and leisurely to learn his method. He is one of the two child psychiatrists who have fascinated me in the past 35 years with their evaluations; the second one being Jim Llubert, MD when he was a young, highly energetic and brilliant child psychiatrist and produced outstanding evaluations.

Joel's method is very unique and constructed by two of his assets predating his medical educations. One of them is his training in law school, before he saw the light of child and adolescent psychiatry and changed his career. Like a very good lawyer, and I assure you there are a few of them around, he looks carefully for clinical evidence and circumstances of its existence. He is the one who really started the evidence-based child and adolescent psychiatry for EB methodology, although many other colleagues have received credit for it.

The second contributor to his methodology is his background in music. He was a choir singer as an adolescent in the prestigious New York City Choral Society. He has learned the structure of the music, and how to harmonize his voice with other people. This has made him an unenviable force in a multidisciplinary or single discipline gatherings where he can really interdigitate his "voice" with the ideas and voices of other people. More importantly, he does an evaluation as if he is composing a symphony. This methodology has been highlighted by a well-known family psychiatrist/psychoanalyst, John Sonne, MD. Sonne proposed that the psychiatric formulation and intervention can benefit from using musical structures just as the musician used a mathematical structure to construct their music.

Joel enters the session by beginning his first movement, by making an exposition of his role, and waits for the patient or the family to make their counter-exposition and their move. The interactions in-between the two sides, will then define the essence of the clinical information and its context. He then bridges to the second exposition and the second theme/movement, by exploring the social, familial and contextual aspects of the patient's symptomatology, adaptive and defensive qualities, and invites the adolescent and their families to provide the second set of the

information. He then bridges further into the third movement, the early development and its context and receives the developmental and genetic information, which would allow him to make a psychological, interpsychic, familial, and biological formulation of a disorder. One can only enjoy optimally and fully Joel's gift by watching him do an evaluation, talk to a kid, consult with the staff and write a note, which is invariably comprehensive and predictably way past the deadline, because of his obsession with the quality.

Joel has been a very committed teacher for Child Psychiatric Fellows from Jefferson, and other medical schools during their clinical assignments. As usual, he has made very strong and longstanding relationships with the graduates in child psychiatry, and enjoys their strong and long-lasting relationships.

Joel's commitment to the Regional Council of Child Psychiatry and the Academy of Child Psychiatry has been intense, deep, and longstanding. He has a very energetic secretary, attends all the meetings, and encourages his colleagues to do so too. He declined an invitation for running for presidency because of the pressure of some family obligations at the time. He has been consistently active in the organization.

Joel is a great person, colleague, and friend. His relationships are enduring and super-longstanding. Some of us are lucky to have kept friends from our elementary school days. Joel's relationships seem to all be "prenatal", and he has made friends when his mother was pregnant with him, and he made friends with the "infants/fetus" of other pregnant women. His commitment to his friends is legendary. He can take 1 or 2 days, or 3 days, to travel to touch base with his old friends that he has kept since his early childhood.

He is very gifted in music, singing with his solid baritone voice; never missing an opera; listening to classical and jazz music, and educates as many friends who are "tune-deaf" to enjoy his talents and gifts.

Joel's commitment to his family and community is unsurpassed. He is a great father and friend to his four children, one son and three daughters. He has unlimited time for them under any circumstances. He has been blessed by a number of grandchildren, particularly two recent ones, who are very young, close in age, and force the grandpa to travel to Colorado frequently as if it was a 20-mile distance. He used to visit his cousin in England every year.

I want to thank Joel for everything that he has done for Clinical Child Psychiatry and listening to his colleagues, including myself, when the going gets rough. I also want to thank him personally for teaching me about violin concertos and ballet which are two of the areas of his great expertise.

How to Address Patients' Social Determinants of Health, Why It's Important



This issue of the *Psychiatric News Alert* previews highlights of this year's Annual Meeting.

MAY 22, 2022 | PSYCHIATRIC NEWS
(https://www.psychnews.org/alert_am2022_2b.html)



Taking the first steps to address patients' **social determinants of health (SDOH)** can be as simple as asking them about the

challenges they are facing in their lives and what's going on in their communities, said one panelist at a session yesterday.

"Clinicians have a front-row seat for viewing the impact of health inequities and our country's failure to address issues around the social determinants of health," said **Patrice A. Harris, M.D., M.A., past-president of American Medical Association**, who has served as a public health administrator, patient advocate, and medical society lobbyist. She believes that clinicians are obligated to share patients' difficult stories with elected officials and the media, added Harris, who was also the first Black woman to be elected president of the AMA and is a former member of APA's Board of Trustees.

After deciding which SDOHs to prioritize in patients' care, Harris said that clinicians should gather a team and develop partnerships with colleagues to help them address these issues. "No

one should feel like they have to have all the answers."

Although there are nearly a dozen social factors that have been clearly identified as important to health, consensus has not been reached on which of these determinants can and should be captured in electronic health records (EHRs), pointed out Regina James, M.D., who posed questions of panelists during the discussion. James is a deputy medical director at APA and the director of APA's Division of Diversity and Health Equity.

Rather than endless discussion of which social determinants to use, Harris said clinicians should focus on understanding what's going on in one's own community and then work on getting the three most pressing social factors added to the EHR. Another barrier to greater attention to social factors is that EHR software vendors sometimes charge extra for modules that allow clinicians to capture and record this type of information. She said clinicians should advocate for lawmakers to hold EHR vendors accountable for creating features that allow clinicians to capture social factors data in a meaningful way from patients.

The Centers for Medicare and Medicaid Services has outlined how to use [SDOH-related ICD-10 Z codes](#) (which range from Z-55 to Z-65) to document, for example, that a patient is experiencing problems related to employment, housing, or obtaining food. Analysis of the data can help improve quality, care coordination, and experience of care with the goal of improving patient outcomes. However, James pointed out these are not widely used.

“All of us want data that can help us help our patients,” Harris replied. But greater adoption of these codes may be an uphill battle, she said, in part because payors are not incentivizing the use of the codes and because of lack of consistency capturing and charting this type of data.

Harris said there is increasing pressure on clinicians to do more to measure patient outcomes. “We do have a moment now where there is increasing focus on mental health, but the criticism (from payors and employers) has been ‘I don’t know if I’m seeing a return on my investment or if I’m seeing more bottom-line employee productivity,’” she said. She said psychiatry needs better tools to measure patient outcomes and whether what psychiatrists are doing is improving the health of patients.



It has been well established that having good social connections is a critical SDOH; it can have a greater impact on longevity than

even an individual’s smoking, drinking, or exercise status, according to **Dilip V. Jeste, M.D. He is a past president of APA and the senior associate dean for healthy aging and senior care** and the Estelle and Edgar Levi Memorial Chair in Aging and Distinguished Professor of Psychiatry and Neurosciences at the University of California San Diego. “We are a social species by nature.”

In fact, research has shown that good social connections help individuals build lasting resilience against distress. For example, after the Hurricane Katrina disaster in New Orleans in 2005, research found that individuals came

together to help each other and that these strong social supports helped shield many people from developing expected posttraumatic stress disorder, despite their experiences, he said.

“There is something wrong with our social and legal systems that our patients are dying 15 to 20 years earlier than the general population, and those gaps in mortality have only increased in the last few decades,” Jeste said. “More of our patients are in jails and prisons rather than in hospitals, and that is not true of the patients of any other medical specialty.”

While better medical care and nutrition and cleaner water supplies have boosted human longevity in recent decades, Jeste said people with mental illness have not benefited from these advances. That’s because individuals with mental illness are less likely to get physicals or preventive screenings. “They go for years with undiagnosed hypertension, which leads to stroke,” he said.

When it comes to treating older patients, Jeste said clinicians often forget to ask them about their alcohol or substance use or fail to pick up on their depression because it is subsyndromal. “Yet this age group has one of the highest rates of suicide.”

For older patients, ageism, loneliness, and social isolation are critical concerns, Jeste said. “Where I come from in India, there is the belief that older people are wiser and have much to contribute. Here the aging of the global population is seen as a ‘Silver Tsunami,’ as if it’s a natural disaster happening to the world.” He prefers to view it as “a Golden Wave,” he said, to help older individuals learn to view their age as a positive. Older adults “can share their wisdom with younger people and provide leadership.”

On December 5th, the Regional Council held their 12th Annual Career Day/Holiday Party at Frankford Hall in Philadelphia. Food and drink were plentiful and fun was had by all attendees. All four door prizes surprisingly, were won by the Senior faculty. Congratulations to Dr. Gurak, Dr. Randall, Dr. Maston and Dr. Graham. Normally at this event, we have a toy drive and ask all attending the Career Day/Holiday Party to bring a toy to the event. Due to Covid, we decided to present an Amazon gift card in the amount of \$500 to an organization whose mission is focused on improving the health and well-being of children, adolescents, and their families. We are proud to announce that "My Sister's Place" has been chosen as our 2021 recipient.

On December 15th, we had the pleasure of going to "My Sister's Place" with the President and President-elect of the Regional Council, Dr. Chioma Iheagwara and Dr. Sylvia Maston, as they presented the \$500 Amazon gift card.

Pictured left to right Carol Coffman; Dr. Chioma Iheagwara; from My Sister's Place, Clinical Director Danett Candelaria; Operations Director Rhonda Clayton; and Parent Child Services Coordinator Alex Hoedeman-Eiteljorg; Dr. Sylvia Maston.



Career Day, December 5, 2021 – Frankford Mill, Philadelphia, PA



Dr. Chioma Iheagwara, President of RCCAP welcoming everyone to Career Day



Dr. Stephanie Brennan, Dr. Randall Gurak, Victoria Moors, MS, Dr. Amy Kim, Dr. Yolanda Graham, Dr. Kevin Walsh and Erica Santos enjoying each other's company and some delicious food and refreshments.



Dr. Consuello Cagande, Mr. William Maston, Esquire, Dr. Sylvia Maston, Dr. Brittany Smith and Dr. Terri Randall smiling for the camera man.



Dr. Paul Ballas joined Dr. Brittany Smith, Dr. Terri Randall, Dr. Chioma Iheagwara, Dr. Kevin Walsh and Erica Santos table hopping and enjoying some spirits.

Dr. Chioma Iheagwara pictured in the middle added a little fun to the day by giving door prizes out won by all Senior Faculty. Dr. Yolanda Graham, Dr. Sylvia Maston, Dr. Randall Gurak and Dr. Consuello Cagande.





Letter to the Editor

Dear Editor,
I loved the newsletter. It had a great balance of getting to know members better, highlighting their work, social justice, and academia. I was very impressed with whoever summarized my talk and thought your addition with cases brought in real world cases nicely. And you're right—the pictures make it visually appealing.

Yolanda Graham, M.D.

Dear Editor,

I like to convey my deep sense of appreciation and gratitude for editing, leading RCCAP News to our members. Few comments, accolades about this July 2021 issue. As you nicely organized the issue has 5 parts, Biography and contributions by leaders, Pictures of the events, reports from CAPP, guests' contributions and knowledge from self-help /advocacy groups.

Report by: Katrina Monta, MS4, Cooper Medical School of Rowan University on Dr. Patricia Harris, Past president of AMA, Biography of Dr. Tami Benton, 1st ever president of AACAP from RCCAP, Bio data of Dr. Anthony Rostain are nicely written and very helpful information about our leaders to our members and readers

A nicely written report by Dr. Ingrid Waldron on NAMI is useful, necessary information about an advocacy group that promotes our profession and mental health.

Reports by Dr. Dhana Ramasamy and Dr. Ashabari Nayak Pellechi on CAPP's Neurodevelopmental disorders are well done and very helpful both for people who attended as well as who couldn't attend.

The scholarly articles written by Dr. Yolanda Graham, and Dr. Pirooz Sholevar on Sex trafficking are very educational to us, all the readers.

And of course, the pictures are wonderful additions to the newsletter and added necessary colour

Thanks again Pirooz for the great job you are doing

Rama Rao Gogineni, MD

News

RCCAP

Regional Council of Child/Adolescent Psychiatry for
Eastern Pennsylvania and South Jersey

President:

Chioma Iheagwara, DO

Past President:

Laurel Weaver, MD, PhD

President Elect:

Sylvia Maston, MD

Treasurer:

Alexander Strauss, MD

Secretary:

Yolanda Graham, MD

Editor:

Pirooz Sholevar, MD (PP)

Deputy Editors:

R. Rao Gogineni, MD (PP)

Randall Gurak, MD (PP)

Administrator:

Carol Coffman

Consider Joining an AACAP Committee

Randy Gurak and Rama Rao Gogineni

Dear RCCAP members and trainee members:

As you, all know that serving on an AACAP committee is a great way to advance your career and experience a unique opportunity to further the field of child and adolescent psychiatry. As a committee member, one can have the ability to advocate for the most pressing issues in the profession, while building leadership skills and knowledge in areas of interest. Through committee affiliation, one can network with senior AACAP members and develop collegial relationships that often result in advancement of career goals and opportunities. One can apply to serve on a committee by finding the list of committees with openings by emailing committees@aacap.org. Send your CV and a Letter of interest on why you would like to become more involved in AACAP by serving on the committee, and why you chose a particular committee. (One can choose three committees) Please note, the committee appointment process occurs every year between July and October. Appointment and reappointment notification letters are sent electronically in September. Read full descriptions of all AACAP Committees through AACAP web www.aacap.org

GET INVOLVED!



Image from the Internet: Committee Involvement Benefits the Tribe — Mashpee Wampanoag Tribe (mashpeewampanoagtribe-nsn.gov)