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Welcome to JAACAP Connect!

What is JAACAP Connect?
All are invited! JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of JAACAP Connect is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need JAACAP Connect?
The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. JAACAP Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

Who reads JAACAP Connect?
All students, trainees, and clinicians who are interested in child and adolescent mental health will benefit from reading JAACAP Connect, available online at www.jaacap.com/content/connect. AACAP members will receive emails announcing new quarterly issues.

Who writes JAACAP Connect?
You do! We seek highly motivated students, trainees, early career, and seasoned clinicians and researchers from all disciplines with compelling observations about child and adolescent psychiatry. We pair authors with mentors when necessary, and work as a team to create the final manuscripts.

What are the content requirements for JAACAP Connect articles?
JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our first edition, the topic and format can vary widely, from neuroscience to teen music choices.

How can JAACAP Connect help with my educational requirements?
Motivated by the ACGME/ABPN Psychiatry Milestone Project®, JAACAP Connect aims to promote the development of the skillset necessary for translating scientific research into clinical practice. The process of science-based publication creates a vital set of skills that is rarely acquired elsewhere, and models the real-life thought process of translating scientific findings into clinical care. To bring this experience to more trainees and providers, JAACAP Connect aims to enhance mastery of translating scientific findings into clinical reality by encouraging publishing as education.

JAACAP Connect combines education and skill acquisition with mentorship and guidance to offer new experiences in science-based publication. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles. Opportunities for increasing knowledge and skills through publishing as education will be available through continued contributions and direct involvement with the JAACAP Connect editorial team, using an apprenticeship model.

Start Thinking About Authorship With JAACAP Connect
What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome, and you are invited.
In This Issue: On Becoming a Child and Adolescent Psychiatrist

Michelle S. Horner, DO

The Summer 2016 issue of JAACAP Connect allows us to reflect on what it means to be a child and adolescent psychiatrist. Variety. Helping others. Integration. We are all drawn to the field for different reasons, but in this issue, we highlight inspiration—the inspiration to overcome limitations and help those most in need: the youth and families who struggle with mental illness.

Inspiration begins with early experiences and grows and matures via support, such as that provided by the Klingenstein Third Generation Foundation (KTGF) Games (http://www.ktgf-games-2016.com/). These “Games” are the stuff of legend: top medical students from around the country join to learn about child and adolescent psychiatry (CAP) from field leaders. Our first article allows all of us to “virtually” attend the Games, as the topic is drawn from the 2016 KTGF Games’ opening speech. Read along as the inimitable John Schowalter, MD, takes us on his journey through CAP, revealing his observations over the years. To learn more about “fantastic wisdom” and what it means to “make it in medicine,” turn to the opening article and ponder these questions with one of our field’s best.

For many, the journey through CAP involves recognizing the unmet needs of others and working with struggling families. In this issue, Dean and Maneta remind us to step back to recognize and deal with countertransference. Like many of the skills we learn, countertransference provides important information, allowing us to better understand the patient and recognize how our personal feelings, past experiences, and expectations influence our impressions and decision making. Understanding countertransference is the first step; recognizing its true impact is a lifelong journey.

Knowledge is power, and one of our most important duties as child and adolescent psychiatrists is outreach to children and their families through education. Rozbruch and colleagues discuss how increasing mental health literacy (MHL) is a fundamental public service that empowers patients to understand and choose the most appropriate treatment options. The authors explain limitations in the current use of MHL and provide tips for working with patients to increase consumer knowledge and therefore improve psychiatric care.

But with all our efforts, if we can’t access the populations most in need, we are missing the mark. Jeffrey and Martini walk us through the integration of CAP within pediatric primary care. After reading this article, you will learn how to lead an integrated behavioral health team, thus extending CAP outreach to the community setting.

The final article of this issue serves as a reminder that children are in need of services all over the globe. The struggle for access to care is ever present in refugee children and their families. Through the eyes of one refugee who “made it out safely,” Lachin discusses the challenges and mental health concerns of today’s refugee children, while taking us on a journey of his own experience as a child refugee.

This issue reveals the troubles, strife, and triumphs that are integral to becoming a child and adolescent psychiatrist. And in keeping with the JAACAP Connect mission, each article provides practical tips that you can use today to help advance your skills and improve treatment of children in need locally and around the world.
SAVE THE DATES!

JANUARY 20-21, 2017

Gabrielle A. Carlson, MD and Manpreet Kaur Singh, MD, MS, Co-Chairs
The Westin St. Francis San Francisco – San Francisco, CA

Register by December 7 at www.aacap.org/psychopharm/2017.
Questions? E-mail meetings@aacap.org.
Making It in Medicine: An AACAP Past President’s Reflections on a Lifetime Career

John Schowalter, MD

On February 27, 2016, 140 medical students from across the country attended the Klingenstein Third Generation Foundation Medical Student Conference to learn about the field of child and adolescent psychiatry. The conference—celebrating its 10th anniversary this year—was held at the Yale School of Medicine. To open the conference, Andrés Martin, MD, MPH, editor-in-chief of the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), invited John Schowalter, MD, Professor Emeritus of Yale’s Child Study Center and AACAP Past President, to address the attendees and reflect on his accomplished and enduring career in child and adolescent psychiatry. The following piece is an adaptation of the talk he delivered. We at JAACAP Connect are excited to share with you the incredibly sage (and humorous) advice of a prominent figure in our field.

—Oliver M. Stroeh, MD, Associate Editor

My mother was born in 1890. I was her youngest child, born when she was 46 years old, during the worst depression in US history and in the midst of a crippling Wisconsin blizzard, which I was often told later made my birth in a hospital “iffy.” Obviously, my parents’ car was 1930s vintage. I understandably might have been born with a two-digit IQ. Yet, I was accepted by the University of Wisconsin Medical School at the age of 19 and was the 2014 University of Wisconsin Medical Alumnus of the Year. I am thus a poster child for the truism that being born smart is dumb luck.

One rule in life is that you should never promise more than you can deliver. This mistake is cleverly highlighted in your program by promising that in less than thirty minutes I will teach all of you how to “make it in medicine.” Please try to believe that I did not personally choose this title. This title and one later-to-be-mentioned item were requested of me.

Perhaps again it’s my age, but I firmly believe that old advice (such as clichés) is usually more valid than a “hot new thing,” whether social or scientific. Clichés sound boring, but that’s the good news. Boring means that they have been worth repeating for a very long time. Just two examples are that many composers’ best-known works are based upon hundreds-of-years-old folk music, and one literary example is that the plot for Hamlet, Shakespeare’s most popular play, is based upon a story first written around 1200 by the Danish monk Saxo Grammaticus. Saxo earned his last name because he could read and write. On the other hand, the relatively new Higgs Boson particle theory is still being challenged regularly by this or that new electromagnetic field finding. And, socially, my male generation’s fascination with baseball caps—visor right, left, front, or back, depending on your personal preference—has given way to the heavy tattoos of Justin Bieber, David Beckham, et al. “Tats” no doubt helped Beckham in December become People Magazine’s 2015 “sexiest man alive.” I’ll give you long odds, however, that by mid-century, tats will also have tumbled in popularity (all fads have a shelf-life), and grandchildren will look at their progenitors’ old, wrinkled ink with sour distaste. Fortunately for me, baseball caps were a lot easier to remove.

Since it is true that both “making it” and “medicine” have various meanings for those in this room, I will narrow my focus on what I have seen and learned as an academic child and adolescent psychiatrist.

I believe that two prime virtues for health professionals are wisdom and compassion. What is wisdom? Facts and data alone are not wisdom. Wisdom develops over time from the synthesis of both information and experience. The most important aspect of experience is that it teaches the common exceptions to the rules that we were taught in the classroom. Wisdom does not require
brilliance, but one must keep one's eyes and ears open and remember: 1) what works? 2) what doesn't work? And 3) why? Wisdom does require curiosity, and wise persons are perpetual students.

Wise people are usually good listeners and tend to be reluctant talkers. Think of the odds against learning anything new while you are the one who is speaking! Wise people are not seen waving their arms in the air to be heard, but are content to wait until less wise people speak first. They thus have more data on which to base their own words. This is almost like cheating.

Fantastic wisdom is found in six brief words carved in stone at the 5th century BCE shrine to Apollo, near Delphi: *Moderation in all things and Know thyself.* Never, I believe, has so much wisdom been packaged in so few words. However, wise people also keep in mind that standard wisdom might not be appropriate for non-standard situations. For example, moderation is not very helpful if somebody is trying to strangle you.

What about for those of you who will choose psychiatry? You choose a profession that is particularly emotionally taxing. A friend of mine was once asked why she went into psychiatry. Her tongue-in-cheek answer was that surgery was not invasive enough. To be effective, we immerse ourselves in people's confusion, despair, violence, and pain. Immersion is often necessary for empathy, and empathy is usually necessary for us to be effective. For example, studies that compare computerized to live-therapist cognitive-behavioral therapies (CBT), at least to date, declare live therapists the CBT winners.

However, for us live therapists, it is just as crucial that we maintain the emotional distance necessary to gain a therapeutic perspective. How, when we immerse ourselves, we can be neither Teflon nor Velcro is a struggle that thoughtful psychiatrists face throughout their careers. As long as you are willing and able to learn, I can assure you that this skill becomes easier with time. You learn the most from your mistakes, but only if you are willing to acknowledge them—at least to yourself. Of course, if you have defense mechanisms that force you to repress or deny your bad judgements, you will continue to repeat them.

What are personal barriers to clinical wisdom? Too much narcissism renders the clinician lacking in the empathy needed to learn about the needs of patients and the interest to truly care about the patient. In a 1927 *JAMA* article, Francis Peabody famously wrote that “the secret of the care of the patient is caring for the patient.” No one said it better before or since. Wise people are often humble because they see life in a broader picture than a selfie. I've already mentioned that being born smart is dumb luck, but some who were born intellectually on third base forever preen about it as though they had personally hit a triple while still in the womb. An absence of humility, since you believe you already know everything, can construct a powerful barrier against learning anything new.

Caring conveys important advantages to a clinician. I'll just mention two examples. First, patients are less likely to conceal worrying and embarrassing data, and this will make you more effective. Second, they are much less likely to sue you. As every insurance company knows, a large percentage of malpractice suits are due to patients' real or perceived interpersonal problems with their physicians. A smaller number is due to egregious physician error. When patients believe that you care about them, it's no surprise that they are more likely to care about you.

Along this same line, it is clear that being likeable is a great advantage in life. One huge skillset for likeability are the words “thank you.” Even moderately well-brought-up persons say “please” when they want something from you. Much rarer, and thus better remembered, are those who actually return after the fact to say “thank you.” “Thank you” is also often the first opportunity to make a positive impression on someone who can help you. Keep in mind that you never get a second chance to make a first impression, and first impressions are the most indelible. For young professionals from all professions, the gift of likeability is a great asset for finding a good mentor, and a good mentor is arguably the largest boon possible to help launch a successful career. By
the way, some advice for those of us who are mentors comes from Coach John Wooden: “A coach is someone who can give correction without giving resentment.” Wooden was coach when UCLA won a record 10 NCAA national basketball championships in 12 years! That feat has never been duplicated. He also knew how to teach teachers. Additionally, for us older folk, perhaps the easiest way to be remembered after death is to be a mentor.

Another sure thing is that anger is a wipe-out of like-ability. Avoid it if you are able. Anger can become addictive and is seldom a good approach to life. As the Buddha, who lived until the age of 80 in present-day Nepal, again during the 5th century BCE, preached: “Anger is a poison that some people drink in the belief that it will kill someone else.” In our current time, cardiologists all agree with the Buddha.

Mentioning to medical students and residents the importance of being even-tempered, caring, and liked may sound no different from what your mother told you before your first day of elementary school. But, I do believe the possession of both IQ and social skills is also linked to “making it in medicine.” You need the former to get onto the bus and the latter to reach the destination that you desire. I remember a concern I had about getting to board that bus. In a pre-med anatomy class, the instructor told me that my sketch of a frog looked like a turtle. For a few nights, I worried by thinking: “OMG, I’ll never get into med school because my frog looks like a turtle, and this is so embarrassing.” I did make the bus, but that was a bad feeling.

The usual sequence of events is that high grades at college are correlated with high MCATs and getting into medical school. Which school we attended will be noted by residency directors, but so will our poise and personality. At least in clinical specialties, how well one does in residency and thereafter is increasingly based on how well one does with people. Please let me stress that earlier high GPAs and test scores are not inversely correlated with later ratings of success, only less correlated. I assume all of us searched to find personal clinicians for ourselves who have both a high IQ and high social skills.

Again, “making it in medicine” covers an extremely broad vista, from a solo practitioner, to members of a group practice, to department chairs, medical school deans, national organization CEOs, etc. In fact, a few years back I attended a small one-day discussion led by four general psychiatrists who had “made it” in terms of having been department chairs and then medical school deans. They enjoyed their “making it” to varying degrees, but all four emphasized an ever-increasing demand for social skills. You may, for example, become a department chair because of your prowess in obtaining lab research grants or because of your national fame from clinical research publications, but suddenly you are also, in a way, responsible for every one of your department’s subsections. Then, as dean, your responsibilities include knowing whom to hire to help you to oversee this or that part of the medical school’s responsibilities to the university’s president, the mayor, the governor, political connections in Washington, DC, etc., etc. You might also have to travel around the country: first to sweet talk potential endowment donors for dermatology, two months later to help obtain pharma funding for a clinical trial, and on and on. All of these very intelligent psychiatrist deans admitted that they had not known, or had chosen to ignore, just how broad a social skillset is required to be a really successful dean.

The leading clerics of the tech industry are, however, very expert in arranging for the tech-savvy staff to work together productively. It was also mentioned that this synergy was there from the industry’s very beginning. This sounds like another Buddha anecdote but really isn’t. Steve Jobs and Steve Wozniak became friends as teens. Jobs never finished college, but at age 19 dropped out to travel to India and study Buddhism. Wozniac spent his time inventing what was to become the Apple I computer. At age 21, drop-out Jobs joined with inventor Wozniac to become a corpo-
rate combination that made them both multi-billionaires. To most of the world, however, the main man at Apple Computer was drop-out spokesman Steve Jobs, not the computer wizard Steve Wozniac.

As I am sure you have noticed, my emphasis for how you, or anyone, “makes it in medicine” has been shifting from what you were and toward who you are. It began with the importance of those youthful talents that are easily measured, such as IQs, GPAs, and MCATs. These are necessary to get onto the medical bus. Then, increasingly, at least in most of medicine, caring, wisdom, and a variety of social skills enter the picture and are also crucial to determine where your bus will go and how long your trip will be to get there.

It is also a fact that everyone’s “Bus to Making It” needs periodic checkups and repairs. “Burn out” sometimes occurs in medicine, just as it does in every other profession. Some of us know what our goals are early in life, others go passively with the flow of opportunities (or disappointments), and a few of us seem not to worry about it at all. Our postgraduate years typically sort out who we are, what we can do, and what we want to do. Keep in mind that the most important definition for success comes with finding your “rightness of fit.” So, as carved in stone 26 centuries ago, “Know Thyself” is usually the best deterrent against wasted time and career disappointment. Unfortunately, these two words are more easily carved in stone than in our being. Most of us have to continually work at them.

There is no universal formula for how to balance one’s professional and personal lives. One first step is to know the quality and quantity of stressors that we can and cannot tolerate. Find out what relaxes you. “Family First” is all species’ number 1 rule for survival. If you have a family, never get so busy that you ignore them, because you thereby also ignore a rule that has truly been around forever. Other effective outlets might include friends, pets, sports, hobbies, the arts, or something completely different. Finding out what rejuvenates you is worthy of the same study as knowing what is healthy for your patients.

Mentioning the family gives me the chance for a “shout out” for working with children and families. After all, I do represent the Yale Child Study Center, which has been caring for children and families for 105 years! Other than a few years away, I’ve worked here for the past 55 years. Are you mostly nice, borderline nice, or mostly not nice? You may know, but I won’t ask for a show of hands. Unless you are mostly nice, I suggest for your own good and for your patients that you avoid entering specialties that begin with “ped” or “child.” Even more than adults, children do better with nice caregivers, even children who are not so nice themselves. I don’t have hard data, but my guess is that medical students self-sort on this. I did my residency here and upon finishing in 1965, I was drafted into the Army Medical Corp. At that time, the US was fighting the very messy and unpopular Vietnam War. The Child Study Center had offered me a faculty appointment when I was discharged. The point of this anecdote about “nice” is that upon returning, Dr. Sally Provence, a full-professor-level developmental pediatrician in charge of our section for infants and young children, gave me a hug and said “welcome home.” She never hugged me again, but I now regularly hug or am hugged by some consenting faculty and staff. That atmosphere of “nice” seems natural for many in our field. Again, I don’t know, but my guess is there are more consenting hugs expressed within specialties that begin with “child” and “ped.”

I obviously believe that physicians who work with young people are special, even beyond being caring and nice. In medicine, as in most areas of life, you can do more good when you detect and fix problems early. This is what our specialty does within the mental health field. It is why I am also very involved in AACAP, or the American Academy of Child and Adolescent Psychiatry. AACAP supports all aspects of our field. I was its president, and I chaired AACAP’s endeavors to change its name from “Child” to “Child and Adolescent,” which was an easy 98% vote. However, to change our specialty’s official name, through the Accreditation Council for Graduate Medical Education, or ACGME, was difficult, combative, and took a few years. I also
formed a committee to mobilize the 1,100 oldest AACAP members into a separate group, newly named the Owls, who have in less than five years raised over $240,000 for medical student and resident travel grants, as well as other endeavors. The energy of AACAP’s oldest generation’s enthusiasm and generosity has surprised everyone, including me! By the way, AACAP’s Annual Meeting is the largest of its kind in the world and is truly international. I encourage you to consider attending this year’s October meeting in New York City to take advantage of excellent mentorship opportunities designed for medical students and residents.

My time is getting short, so I will mention that second request I was given, besides this talk’s title. I was urged to make my talk “funny as hell.” Since neither religious nor most non-religious people think of hell as hilarious, I believe I was given a low-bar challenge as compensation for the toughness of the title task. I do, however, advise you to never try to be funny on demand. It is next to impossible. I’ve been caught a few times, and the worst was when I was elected to the Benjamin Rush Society. The BRS is named after the only physician who signed the US Declaration of Independence, and the group considers itself very exclusive. It began with 13 members (after our country’s original 13 colonies—get it?), and after more than 40 years has raised its limit to no more than 39 members nationally—that’s three times 13. I was number 28. When introduced at my first meeting, I was told by the president that I was voted in because a few members said I was funny. He then added, “So, say something funny!” I failed miserably. Fortunately, they had no impeachment process, and I did eventually become the BRS president. I also enjoy taking solace from the famous words of Shakespearian actor Edmund Kean. In Shakespeare’s day, comedies were generally defined as plays in which a young couple overcomes obstacles and marries, while tragedies end with the protagonist’s death. A friend came to try to comfort Kean on Kean’s deathbed. The friend later wrote that in order to comfort the comforter, Kean had tried to reassure *him* by saying that “Dying is easy. It’s comedy that’s hard.” Although from my presentation it may not seem that working in child and adolescent psychiatry is very funny, I do hope I made clear that it can be fun.

My final point might fulfill my talk’s title after all. And, it may no longer come to you as a big surprise. It is that wise persons realize that the most important judge of whether or not you have made it is you. If you and those you care for feel satisfaction in what you have done, you have made it. Perhaps a better title for this talk would have been, “How to Make It as Me.” As the Irish playwright Oscar Wilde once counseled: “Be yourself. Everyone else is taken.”

Take Home Summary

One starts out in life with various bits of good luck and bad luck. While these biopsychosocial factors are powerful, we should try not to be so brash as to take credit for the positives, and we should learn stratagems to lessen our negatives. For physicians, I stress the power of obtaining wisdom, compassion, and insight.

About the Author

**John Schowalter, MD,** graduated from the University of Wisconsin School of Medicine and received its 2014 Distinguished Alumnus Award. His child psychiatry training and career were at the Yale Child Study Center where he was residency training director for 27 years, specialized in the care for adolescents, was the first Albert J. Solnit Professor, and served as the department’s Interim Chair. He was president of five national organizations, and for AACAP led its efforts to change the specialty’s name from “child” to “child and adolescent” psychiatry, obtain the ACGME’s approval for a combined 5-year residency in pediatrics, psychiatry, and child psychiatry, and formed an active group for the AACAP Life Members.

**Disclosure:** Dr. Schowalter reports no biomedical financial interests or potential conflicts of interest.
SAVE THE DATES!
Early Bird Registration Deadline: September 15, 2016
Online Registration Closes: September 30, 2016

Visit www.aacap.org/AnnualMeeting/2016 for the latest Annual Meeting Information!
Skills for the Child and Adolescent Psychiatrist Within the Pediatric Primary Care Setting

Jessica Jeffrey, MD, MPH, MBA, and D. Richard Martini, MD

Behavioral health symptoms are a common presenting complaint within the pediatric outpatient setting. In fact, behavioral health symptoms account for 15% of chief complaints and inform 50% of presentations within outpatient pediatric practices. Yet, despite the pervasiveness of behavioral health symptoms, only 20% of children with a behavioral health disorder in the United States receive treatment. In order to increase access to high-quality behavioral healthcare, pediatric settings are beginning to implement integrated behavioral healthcare programs. Within integrated behavioral health programs, child and adolescent psychiatrists collaborate with pediatric primary care clinicians and care managers and improve patient outcomes.

The American Academy of Pediatrics recognizes that pediatric primary care clinicians have a responsibility to prevent and address behavioral health problems. However, barriers to the provision of behavioral healthcare by pediatric primary care providers exist; these include short appointment times, inadequate reimbursement for behavioral health services, limited specialized training in behavioral health issues, and challenges to accessing child psychiatrists for consultation. To promote the successful delivery of behavioral health services within the pediatric primary care setting, child and adolescent psychiatrists must work collaboratively with the integrated behavioral health team. The role of the child and adolescent psychiatrist within an integrated behavioral health team represents a paradigm shift from traditional outpatient psychiatric clinical practice, and one in which a distinct skill set and clinical practice style are required to guide care. This article briefly reviews the composition of a typical pediatric primary care integrated behavioral health team, and it provides an introduction to three basic skills a child and adolescent psychiatrist should possess in order to work effectively within the integrated behavioral health model.

The Integrated Behavioral Health Team

The integrated behavioral health team generally includes the pediatric primary care provider, care manager, and consulting child and adolescent psychiatrist, who also functions as the team’s leader. Behavioral health services are delivered within the outpatient pediatric clinic setting. Within an integrated behavioral health team, the primary care provider’s role includes initial assessment of behavioral health symptoms and initiation of treatment, including prescription of psychotropic medications as appropriate. The care manager is embedded in the pediatric clinic with the pediatric primary care provider. He or she provides care coordination services, monitors treatment progress, administers brief evidence-based interventions and, as needed, facilitates referrals to more intensive levels of care. Depending on the integrated care practice, a child may be referred to another behavioral health provider to receive a specific evidence-based treatment. Often nurses, social workers, or psychologists undertake the role of care manager. However, the American Academy of Child and Adolescent Psychiatry (AACAP) recommendations for the role of care manager allow for practices in smaller communities to use staff members or even local family members whose children have received behavioral health services as care managers. The use of staff members or local family members eliminates the need for behavioral health services as care managers. The use of staff members or local family members eliminates the need for behavioral health training and focuses the position more on triage and communication. The primary role of the child psychiatrist within the pediatric primary care setting is to perform consultation-liaison functions. The child psychiatrist reviews the care manager’s caseload with the care manager, consults with...
the pediatric primary care clinician and care manager regarding patients not making clinical improvements, and directly evaluates treatment-resistant patients and those with more severe behavioral health issues. The child psychiatrist may be embedded part-time within the pediatric primary care clinic or available via telepsychiatry platform. To guide care within an integrated care setting, a child and adolescent psychiatrist should have familiarity with measurement-based treatment to target principles, be able to effectively deliver both indirect and direct consultation services to the integrated care team, and embrace the role as a leader of the interprofessional team. The child and adolescent psychiatrist should also either be available to provide services for patients who require tertiary psychiatric care or be able to provide a referral for those services. Importantly, the integrated behavioral health team should also support active roles for the patients and families on the treatment team that will encourage their participation in education, self-management, and peer-supported activities that encourage recovery and wellness.

Three Basic Skills for the Child and Adolescent Psychiatrist Within the Integrated Care Team

1) Familiarity with measurement-based treatment to target principles: Measurement-based treatment to target includes systematic review of patients’ progress in treatment, as tracked through examination of patients’ scores on psychometrically validated rating scales within a registry system. Rating scales are generally administered within the primary care setting by the care manager, although they may also be administered within a more specialized behavioral health setting as needed. Patients generally complete rating scales at 3-month intervals. The care manager working on the integrated behavioral health team is assigned the role of tracking patients’ progress in treatment. The child psychiatrist and care manager review the care manager’s caseload together, with emphasis on patients who are not experiencing symptom relief, as demonstrated by lack of improvement in behavioral health rating scale scores. With the goal of remission of symptoms, the child psychiatrist may recommend increased dose or a change in psychotropic medication (prescribed by the pediatric primary care provider), a change in therapy approach, or an increase in treatment intensity. Within the stepped-care approach, the child psychiatrist must be comfortable using the combination of registry data and his or her clinical judgment to determine when a patient requires direct evaluation by the child psychiatrist, rather than indirect provision of care through guidance provided to the pediatric primary care clinician and care manager. Providing the least extensive care needed for positive results is referred to as the stepped-care approach to treatment and is a fundamental concept within integrated care models.

The child psychiatrist should be familiar with rating scales commonly used to track progress in treatment through a registry system. In addition to being able to use these rating scales to track treatment progress, the child psychiatrist should feel comfortable teaching pediatric providers about use of the rating scales for screening and treatment monitoring. Measures to assess depression, anxiety, and attention-deficit/hyperactivity disorder (ADHD) symptoms may be most commonly employed. Please see Table 1 for commonly used rating scales in pediatric integrated behavioral health settings. It is preferable to use measures that are readily accessible, without cost, within the public domain.

2) Comfort with providing consultation services to the integrated care team: A primary role of the child psychiatrist within an integrated behavioral health team is to engage in indirect service collaboration with care managers and pediatric primary care physicians. As appropriate, child psychiatrists also provide direct consultation services when they evaluate a patient in-person. The child psychiatrist may decide to provide direct care for a patient who has not been making progress in treatment.

Indirect service collaboration requires that the child psychiatrist feels comfortable with diagnosing and providing treatment recommendations (including medication, therapy, most appropriate level of care) for patients he or she has not directly evaluated. Components of indirect service collaboration include caseload-based
supervision with a care manager, as described above, and consultation with the care manager and pediatric primary care provider. Within the integrated care model, the child psychiatrist must be able to efficiently review medical records and glean important clinical information from the care manager’s or pediatric primary care provider’s case presentations. The child psychiatrist must learn which questions are most important to ask the case presenter in order to obtain enough information to make a working diagnosis and initial recommendations. Importantly, the child psychiatrist needs to be able to rule out high-risk conditions, which may immediately require a higher level of care, and triage patients to the most appropriate level of care (i.e., treatment within primary care integrated behavioral health model vs. referral to a community provider for more specialized treatment). The child psychiatrist synthesizes the information provided, creates an integrated care plan, and supports the team in implementation of the care plan. Due to the fact the child has not been evaluated directly, the child psychiatrist must be comfortable initiating a treatment plan without an exact diagnosis; the treatment plan within an integrated care case review is an iterative process. The ambiguity inherent in providing indirect consultation may create discomfort for child psychiatrists who are not familiar with practicing within the integrated behavioral health model. However, within the integrated care model, the child psychiatrist needs to value practicality and the importance of beginning treatment in order to prevent negative health outcomes over certainty in diagnosis. Focused clinical recommendations may be provided to the team over the telephone, through written report, or a telepsychiatry platform, as indicated by the workflow within the clinic setting.

In order to effectively provide consultation services, the child psychiatrist needs to be familiar with the presentation and treatment of behavioral health conditions as they commonly present within the primary care setting. This requires attunement to somatic manifestations of behavioral health conditions, such as depression and anxiety, as somatic symptoms are the principal chief complaint within primary care settings. Additionally, the child psychiatrist will often be asked to provide recommendations for children with treatment-refractory behavioral health conditions, as more straightforward cases of depression and anxiety may be effectively treated by the pediatric primary care provider. The child psychiatrist should understand the common reasons for nonresponse to treatment. For instance, he or she should be attuned to the potential of misdiagnosis, as well as be able to investigate whether a child is taking an inadequate dosage of medication or is experiencing barriers to treatment that make it difficult to be adherent to treatment recommendations. When a patient’s symptoms are not improving, the child psychiatrist may

### Table 1. Commonly Used Rating Scales in Pediatric Integrated Behavioral Health Settings

<table>
<thead>
<tr>
<th>RATING SCALE</th>
<th>DESCRIPTION</th>
<th>AGES</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9</td>
<td>9 items; ≥ 12 years 12</td>
<td>≥ 12 years</td>
<td>12</td>
</tr>
<tr>
<td>SCARED</td>
<td>41 items; Assesses symptom domains such as somatic symptoms, school avoidance, social anxiety, separation anxiety, and generalized anxiety</td>
<td>≥ 8 years</td>
<td>13</td>
</tr>
<tr>
<td>SNAP-IV</td>
<td>18 items; 6-18 years 14</td>
<td>6-18 years</td>
<td>14</td>
</tr>
<tr>
<td>Vanderbilt ADHD Parent Rating Scale</td>
<td>55 items; 6-12 years 15</td>
<td>6-12 years</td>
<td>15</td>
</tr>
<tr>
<td>Parent–Young Mania Scale</td>
<td>11 items; 5-17 years 16</td>
<td>5-17 years</td>
<td>16</td>
</tr>
</tbody>
</table>

Note: ADHD = attention-deficit/hyperactivity disorder; PHQ-9 = Patient Health Questionnaire 9; SCARED = Self-Report for Childhood Anxiety Related Emotional Disorders; SNAP-IV = Swanson, Nolan and Pelham–Fourth Revision.
decide to directly evaluate and treat the child. However, once the child has been stabilized and is on maintenance treatment for a stable, non-psychotic disorder, the pediatric primary care provider is expected to resume care, including refill maintenance.

As a key component of providing consultation services, the child psychiatrist needs to be proficient in the evidence-based practices commonly employed within the primary care setting. The child psychiatrist has a unique opportunity to act as a teacher and supervisor to the care manager in order to facilitate the delivery of evidence-based practices. Common evidence-based practices include motivational interviewing, behavioral activation, cognitive-behavioral therapy, and parent behavior management skills training approaches, such as Triple P for Primary Care. The child psychiatrist should also be able to guide the care manager and pediatric primary care provider to provide anticipatory guidance for patients. Primary care physicians should understand when a patient requires a higher level of care and the resources than are available. The child and adolescent psychiatrist should, therefore, familiarize the primary care practitioner with the vulnerabilities that place a patient at greater risk and provide information on available community-based educational and behavioral health resources.

### 3) Ability to lead an interprofessional integrated behavioral health team:
Within an integrated behavioral health team, the child psychiatrist assumes the very important role of team leader. As the team leader, the child psychiatrist is responsible for guiding patient care activities, as described above, and educating pediatric primary care providers and care coordinators as to best practices in behavioral health screening, evaluation, and treatment (medication and therapy). Additionally, the child psychiatrist should highlight risk factors for poor behavioral health and functional outcomes and promote preventive interventions.

In order to create and maintain a strong team, the child psychiatrist needs to function effectively as a team leader. He or she should to be able to engage the interprofessional team and build relationships characterized by trust and mutual respect with the team members. To

<table>
<thead>
<tr>
<th>FAMILIARITY WITH MEASUREMENT-BASED TREATMENT TO TARGET PRINCIPLES</th>
<th>COMFORT WITH PROVIDING CONSULTATION SERVICES</th>
<th>ABILITY TO LEAD AN INTERPROFESSIONAL TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Possess knowledge of rating scales</td>
<td>■ Engage in indirect service collaboration with care managers and pediatric primary care providers</td>
<td>■ Educate pediatric primary care providers and care coordinators as to best practices in behavioral health screening, evaluation, and treatment (medication and therapy)</td>
</tr>
<tr>
<td>■ Employ a stepped-care approach to treatment</td>
<td>■ Be comfortable with diagnosing and providing treatment recommendations for patients not directly evaluated</td>
<td>■ Highlight risk factors for poor behavioral health and functional outcomes and promote preventive interventions</td>
</tr>
<tr>
<td>■ Provide consultation and supervision to care manager</td>
<td>■ Provide direct consultation services for patients who have not been making progress in treatment</td>
<td>■ Cultivate effective interpersonal and communication skills to create a strong interprofessional team</td>
</tr>
<tr>
<td></td>
<td>■ Possess familiarity with the presentation and treatment of behavioral health conditions as they commonly present within the primary care setting</td>
<td>■ Provide tertiary child and adolescent psychiatric support to the primary care practice</td>
</tr>
<tr>
<td></td>
<td>■ Be proficient in evidence-based therapies commonly employed within the primary care setting</td>
<td></td>
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</tbody>
</table>

Skills for the Child and Adolescent Psychiatrist Within the Pediatric Primary Care Setting
this end, it is important for the child psychiatrist to cultivate effective interpersonal and communication skills. He or she should collaborate well with team members and acknowledge their dedication to the patients they serve. When communicating patient recommendations, the child psychiatrist needs to be able to skilfully explain reasons for treatment approaches in order to promote the team’s understanding of the plan and maintain positive working relationships. Please see Table 2 for an overview of the basic skills for the child and adolescent psychiatrist within the integrated care team.

Further Your Knowledge

The three basic skills described above may be learned through self-study with hands-on experience and formal education. The textbook Integrated Care: Working at the Interface of Primary Care and Behavioral Health, edited by Lori Raney (2015), provides an excellent overview of integrated behavioral healthcare and discussion as to how to build skills in this emerging field. The AACAP Systems of Care, Collaboration with Primary Care website contains a wealth of information about integrated care and collaboration with other medical professionals. Additionally, a previous article written by Jeffrey and Martini (2015) for JAACAP Connect, “Behavioral Health Integration Within Primary Care: A Primer,” provides an overview of integrated behavioral health principles that may be useful to gain familiarity with this treatment model. Formal training in integrated care is offered by the University of Washington Department of Psychiatry and Behavioral Sciences through a one-year fellowship.

Conclusion

The role of the child and adolescent psychiatrist within an integrated behavioral health team represents a paradigm shift from traditional outpatient psychiatric clinical practice. Three basic skills a child psychiatrist should possess to work effectively within the integrated behavioral health model include familiarity with measurement-based treatment to target principles, comfort with providing both indirect and direct consultation services to the integrated care team, and the ability to lead an interprofessional integrated behavioral health team. These skills can be developed through self-study with hands-on experience, and formal education.

Take Home Summary

Within integrated behavioral health programs, child and adolescent psychiatrists collaborate with pediatric primary care clinicians and care managers in order to provide high-quality behavioral healthcare for children. Child psychiatrists can learn the skills required to work effectively within the integrated behavioral health model and define their role in the pediatric health home as well as in population-based systems.

References


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Disclosure: Dr. Jeffrey reports no biomedical financial interests or potential conflicts of interest.

Dr. Martini reports no biomedical financial interests or potential conflicts of interest.
The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to introduce a new and improved JobSource, an advertising and recruiting tool to assist AACAP members and related experts looking for new career opportunities, and to help employers find the most qualified child and adolescent psychiatrists.

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With questions, please contact Samantha Phillips, Membership & Communications Coordinator, at sphillips@aacap.org.
Toward Greater Information Symmetry: Mental Health Literacy in Young Patients and Their Families

Erica V. Rozbruch, BA, Andrea S. Wister, BA, Robert D. Friedberg, PhD, ABPP, and Sandra Trafalis, PhD

Mental health literacy (MHL) refers to acquired knowledge and attitudes about psychiatric disorders and their treatment options. Increased MHL allows for behavioral health care consumers to know about diagnoses, how they are being treated, types of evidence-based treatments, and what it means when the treatment being delivered is truly evidence-based. Many children and families are reluctant to seek psychiatric care due to reasons related to limited MHL, including not being able to identify emotional/behavioral problems, as well as not knowing if and where effective treatment options are available. Additionally, potential behavioral health care consumers may also hold negative attitudes toward mental health treatment. This commentary argues for wider MHL efforts by illustrating the importance of increasing consumer knowledge and offering concrete recommendations for enhancing MHL in the community.

The provision of health care, including behavioral health care, suffers from information asymmetry. Simply, clinical providers are presumed to know more about psychiatric illnesses and the effective treatments for them than patients. Truncated MHL exacerbates this already high information asymmetry. Increased MHL equalizes this imbalance by empowering patients with scientifically based information that is readily digestible. By digestible, we mean several things. First, the material should be attractive enough to whet patients’ interests. Second, complex information should be sufficiently simplified to be made accessible in bite-sized chunks of knowledge. Third, collaborative exchange of facts allows patients to mindfully chew over the material and evaluate its applicability to their unique circumstances so the information can be metabolized. Informed patients armed with accurate facts will seek out empirically based treatment and become genuine collaborators in their treatment.

Sadly, many families and young patients hold negative beliefs about mental health diagnoses and treatment. Often, these beliefs are related to the stigma of mental illness. Essentially, stigma is a bias or prejudice that is based on wholly inaccurate information or distorted facts. One of the most prominent stigmas around mental illness is that it is a fundamental flaw in the person, and not a condition that is amenable to treatment.

Not surprisingly, stigma and other negative beliefs about mental health treatment reduce care-seeking. Increased MHL decreases stigma by helping patients see universality in their condition and by reducing the sense that distress is a function of personal flaws.

Jorm argued that the chances of receiving genuine evidence-based services increases if families are aware that they are available and they recognize that these approaches outperform other treatment alternatives. In general, patients receiving behavioral health care services are unaware of what treatments are effective and whether the care they receive is evidence-based. However, Jorm emphasized that lay people tend to rate peers and family sources of help more favorably than professional practitioners. Additionally, he emphasized that psychiatric/psychological specialists are viewed less positively than other help givers. Indeed, these findings suggest lowered level of public confidence in mental health providers. MHL bridges the divide, facilitates collaboration not only in a clinical setting but in a wider social milieu where friends’ and families’ opinions
are important and could improve the relationship between people seeking services and help givers.

Low MHL and reduced public confidence are exacerbated by service providers’ inaccurate self-labeling. Unfortunately, too many providers present themselves as offering evidence-based treatments, but they apply the procedures improperly.\(^7\) For example, recent studies demonstrate that there is low concordance between practitioners’ labeling themselves as “cognitive-behavioral” in orientation and their actual practices.\(^8\) When these self-labeled cognitive-behavioral therapists were observed, raters saw little evidence of proper application of the approach.\(^8\) With increased MHL and a greater understanding of evidence-based treatments, adolescents and their families should be able to recognize whether they are receiving evidenced-based treatments for their psychiatric disorders.\(^1\)

**Recommendations for Improving MHL**

Creating materials that increase mental health literacy is the ultimate translation challenge. One place to begin thinking about MHL is how to translate the language being used. Psychological treatment, including interventions provided by psychiatrists, psychologists, and all manner of therapists, is all too often punctuated by jargon and obfuscating concepts. One ideal of MHL would be to create a Rosetta Stone designed to decode the scientific, historical, and professional languages used by treatment providers and researchers, which would allow the public to understand what the caregiving professionals mean when they talk about disorders, treatments, and expected outcomes.\(^9\) Because a perfect Rosetta Stone is unlikely to come, one goal of MHL is to be clever, creative, and engaging in how information is communicated, so that the lay public can have a clear sense of what the professional caregivers are actually saying.

One of the implications of improved MHL is an understanding of what actually is expected to happen and what should happen: that is, outcomes, such as community agencies’ clinical performance. In addition to increasing the availability of evidence-based treatment for patients in the United Kingdom, the Improving Access to Psychological Therapies project (IAPT) offers implications for improved mental health literacy. For instance, community agencies’ clinical performance is public knowledge. Skills required by attending therapists, training curricula, and supervisory guidelines are all required to be posted on the clinic’s website.\(^10\) Additionally, outcome metrics and other benchmarks are also made transparent. Thus, consumers can see how local agencies and providers are doing with their patients.

Kaslow\(^8\) also recommended a litany of strategies for improving MHL, including print media, radio and TV, websites, TED talks, podcasts, and webinars. Additionally, newspapers in large media outlets (The New York Times, The Washington Post, Chicago Tribune, The Boston Globe, The Wall Street Journal, San Francisco Chronicle, etc.) commonly publish science and human behavior columns. Recently, The Huffington Post in the United Kingdom issued a special edition on children’s mental health guest-edited by Catherine, Duchess of Cambridge. Appealing and popular lay spokespeople who are champions for mental health are powerful messengers. Greater collaborations between scientists, clinicians, and high-profile community advocates can only aid in engaging the public in greater MHL.

While partnerships with community advocates are valuable, MHL initiatives cannot be totally outsourced either. Social and electronic media are “super powers” for disseminating information. Like any super power, it can be used well to deliver accurate scientific information or misused to convey misleading misinformation. Behavioral health care scientists and clinicians need to harness this communicative muscle so social media outlets such as Twitter, Instagram, YouTube, and blogs can become better vehicles for MHL. The American Academy of Child and Adolescent Psychiatry (AACAP) has a presence on Twitter and regularly publishes informative tweets. An excellent exemplar is The Psych Show, hosted by psychologist Ali Mattu, which presents complex material on mental health in an entertaining and accessible way on YouTube. In many ways, The Psych Show is a YouTube cousin to the popular science show...
Cosmos. The Psych Show has over 1,300 subscribers and offers a variety of episodes, with one episode earning over 57,000 views in 6 months.

The New York Child Study Center and its mother-ship, the New York University Langone Medical Center, produce creative and far-reaching MHL programming. Most notably, Doctor Radio is a Sirius XM satellite radio station that is home to About Our Kids, a show hosted by child psychiatrist Jess Shatkin, MD, MPH, and psychologists Alexandra Barzvi, PhD, and Lori Evans, PhD. The show discusses pediatric behavioral health and presents information in a consumer-friendly but not overly “pop psychology” fashion, based on a dialogue between experts, professionals, and people calling in. Each show includes a guest who offers cutting-edge information to listeners. Unfortunately, because the show exists on a subscription radio channel, its scope may be limited to listeners who can afford the subscription fee. This comment is not at all meant as a dig at satellite radio, but it does point out that access to good information remains dependent on income. Developing projects that create greater access for many people is necessary.

Help Your Keiki (HYK) is an innovative, interactive website for parents, children, and practitioners, which facilitates low-cost access to state-of-the-science information for pediatric behavioral health care concerns. HYK was built to be consumer friendly and actively involved mental health consumers in its construction. The site is jargon free and presents the latest empirical information in digestible forms to consumers. In addition to teaching website visitors about treatments that work and offering them data-driven coping skills, HYK educates consumers about how to evaluate clinicians’ competence.

Conclusion
Educing consumers about psychiatric disorders and their treatment is fundamentally a public service. Spreading the word about effective treatments will empower people to get the best care. The more people know, the better they are at evaluating the adequacy of their services and the more involved they can be in their own outcomes. Consequently, public confidence in behavioral health care can grow. Psychiatrists and other behavioral health care providers should collaborate on implementing MHL projects that provide state-of-the-science information in an entertaining, accessible, and actionable way.

Take Home Summary
Increasing mental health literacy (MHL) in young people and their families is a vitally important public health initiative. Improved mental health can lead to greater service seeking and patient empowerment. Creative and engaging MHL products are needed and should include traditional as well as innovative distribution outlets such as YouTube, podcasts, webinars, and Twitter feeds.

References
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Disclosure: Ms. Rozbruch reports no biomedical financial interests or potential conflicts of interest. Ms. Wister reports no biomedical financial interests or potential conflicts of interest. Dr. Friedberg has received royalties from Guilford Press, John Wiley, Routledge, and Professional Resource Press and is on the speaker faculty of the Beck Institute for Cognitive Therapy and Research. Dr. Trafalis reports no biomedical financial interests or potential conflicts of interest.

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Countertransference and Child and Adolescent Psychiatry: Bringing Theory Into Practice

Jason Dean, MD, and Eleni Maneta, MD

Countertransference, in its broadest definition, refers to the clinician’s emotional response to the patient. These reactions can be positive; however, they can also include negative feelings such as dislike, despair, or even aggression and hate. If negative feelings go unrecognized, they can lead to enactments of the countertransference, where the clinician unknowingly acts out his or her feelings toward the patient in the treatment.

Though countertransference has been extensively addressed in the psychotherapy literature, it has been largely neglected in the child psychiatry literature. One theory may be that countertransference is often stronger when working with children, leading clinicians to avoid the topic. For instance, many clinicians have difficulty seeing children suffer, struggle with the overlap between their work and their personal experience with parenting, and find working with families particularly challenging. In addition, the field of psychiatry in general has shifted from a psychoanalytic model to a blended biological paradigm, which lends itself less to the identification of countertransference. This is particularly true in the inpatient setting, where managed care has placed a strong emphasis on significantly shorter lengths of stay. Yet it is specifically on an inpatient unit where transference and countertransference can become most notable, as patients in crisis often struggle with attachment difficulties or emerging personality psychopathology.

For example, one of our patients was a young boy with a history of neglect and abuse, whose severe behavioral outbursts led to frequent physical restraints. Despite the best efforts of the unit team, he seemingly thwarted all attempts to help him control his behavior. Over time, the team began to feel frustration and anger, signifying the development of negative countertransference. The idea of feeling anger toward an ill child, however, is incredibly uncomfortable, and this discomfort can lead clinicians to adopt defense mechanisms that play into the enactment of the countertransference. In this case, some team members inadvertently began avoiding the patient to avoid provoking a behavioral outburst. The result was that he did not receive the intensive attention and limit setting he needed, which led to escalating behaviors that sometimes required physical containment. Another common defense in this case was the displacement of anger onto the patient’s father, who represented a more acceptable target. The negative countertransference was further fueled by a sense of impotence that set in when most attempts at helping the patient control his outbursts were ignored or sabotaged. Behavioral plans were torn up, and the patient began escalating in response to even the slightest triggers. As a sense of futility set in, there was also a strong desire to discharge the patient despite his ongoing challenges. Ultimately, the inpatient psychiatric unit could not provide what this patient desperately needed: long-term, stable attachment. Once that became clear, long-term residential placement was pursued.

Recognizing and understanding the negative countertransference was essential to the patient’s treatment while he remained under our care. Such an approach allowed us (the team) to understand his behavior in an interpersonal framework and to address our own contribution to his dysregulation. It also allowed us to be mindful of our own motivations in making treatment decisions in order to avoid harmful enactments of the countertransference.

From Theory to Practice

Initially, countertransference was viewed as entirely undesirable, a contaminant of the otherwise pure and objective therapeutic relationship. Early clinicians endeavored to avoid countertransference feelings
toward their patients, especially when these feelings were negative. Klein and Bion,5-8 however, described how negative countertransference is a natural and even desired aspect of treatment, where understanding and tolerance of countertransference, rather than avoidance, could lead to healing. They describe how these strong countertransference feelings, such as hatred or anger, must be contained, metabolized, and returned to the patient, who re-internalizes them and learns how to tolerate them.

Negative countertransference can sometimes be generated through the process of projection and projective identification, in which an individual denies an internal aspect of his or herself and experiences it as coming from the external world.5 For instance, a patient who is unable to tolerate an internal feeling of anger may experience the clinician as being angry, even if this is at odds with objective reality. The patient may then cause the clinician to experience these feelings himself; thus, the clinician may actually come to feel angry. The theorized benefit of this process is that the individual is able to place an unwanted aspect of the self in the external world where it can be controlled and contained.

Of course, not all countertransference feelings are due to projection. Countertransference can also arise secondary to the clinician’s own internal biases. Even the most skilled clinicians will sometimes feel very strong positive or negative feelings toward a patient that may stem from their own internal psychological makeup. For example, a clinician who has experienced abuse may develop a strong desire to rescue an abused child, while simultaneously developing strongly negative feelings toward the child’s parents. Alternatively, a clinician who has difficulty with dependency may be repelled by a dependent patient. These feelings will be out of proportion to what may be experienced by a different clinician. In these examples, the countertransference stems from the internal world of the clinician, independent of the patient. It is important to distinguish between the two forms of countertransference, between a reaction based on one’s own psychology and an emotional state that has been projected onto the clinician by the patient. One clue might be that the emotions triggered through projective identification often feel foreign and unexpected, while those that are secondary to internal factors feel more natural.

On an inpatient unit, many patients, particularly those who have suffered disruptions in early relationships, utilize the defense mechanism of projective identification. These patients may split the unit staff or create chaos around them, effectively projecting their chaotic internal world into the milieu.8 The chaos may also seep through to the clinician, who might then start to feel anger toward the patient. Systematically identifying these emotions within the clinician, containing them, and presenting them back to the patient can help the patient learn to modulate his or her own emotions.8 In order to do so, the treatment teams could consider holding regular meetings to discuss clinicians’ feelings toward patients. Such meetings can normalize these reactions and bring them into context. Understanding these feelings can also help the team understand the patients’ internal world, as some of these feelings may be related to projective identification. By working together to contain these projections, rather than avoiding negative feelings, the team will effectively contain the patients, leading to greater stability and improved distress tolerance.

Conclusions
In our view, countertransference is as relevant today as ever, especially in the treatment of complex patients on an inpatient unit. It is essential to acknowledge countertransference and the ways in which it can influence treatment. It is also imperative to continue to train the newer generations of psychiatry residents and fellows to recognize and manage countertransference.

Properly dealing with these feelings on an inpatient unit requires patience, introspection, and strong team leadership. Especially when the team is considering an intervention that could represent an enactment, such as early discharge, initiation of a sedating medication, physical or chemical restraint, or other restrictions on the unit, the motivations for these decisions should be closely reviewed. This process requires hard work. If we
are willing to exert ourselves and honestly face our reactions to our young patients, such perseverance will be rewarded when even the most challenging patients can receive effective treatment on an inpatient unit.

**Take Home Summary**
Clinicians should always be mindful of countertransference, particularly when working with children and adolescents, regardless of the treatment setting. Identifying negative countertransference can provide insight into the patient’s internal state, as they may be projecting their internal world onto their environment. Ultimately, working through countertransference can improve treatment outcomes.

**References**

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**Disclosure:** Drs. Dean and Maneta report no biomedical financial interests or potential conflicts of interest.

**JAACAP September Issue — Available Now!**
“Apples and oranges” might be your first reaction to this month’s Translations article, *Zebrafish: A Translational Model System for Studying Neuropsychiatric Disorders*. What could such a distant cousin on our genetic family tree have in common with us? Nevertheless, the zebrafish possesses a central nervous system similar to a mammal’s, which allows researchers to observe their neurobiological development by virtue of their fast-growing, transparent embryos, and provides a glimpse of how development is affected by malfunctioning risk genes. Figure 1 features a thorough demonstration of the functional analysis, exhibit A of this fruitful exploration.
AACAP’s 2017 Legislative Conference and Assembly Meeting will take place in Washington, DC, from May 11-13, 2017. Join us for both events to advocate for children’s mental health.

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Mental Health in a Migrant Crisis: Through the Eyes of a Refugee

Ishaq Lachin, BA

I still remember the night we left. How could I forget it? It was my birthday, and while I didn’t know what was going on, I had my suspicions that things were different. Like any other day, I had spent the afternoon with my grandmother, but when my parents came to pick me up, she began to cry and wouldn’t let go of me. There was hardly a day that went by that I didn’t see my grandmother, and I had never seen her cry before that moment. As I stood by her front door confused, I tried my best to console her. I told her not to worry and that I would be back tomorrow. It would be nearly fifteen years before I would see her again. That night we had a birthday party, but I didn’t think it was just for me. It was too big and had too many people. No one told me it was actually our going away party. I went to bed thinking everything was fine, but when I woke up later that night startled, I found myself in my mother’s arms in a car I had never seen before. We were finally leaving Iraq. In a country torn by continuous conflict, my parents decided to leave everything they had built behind, in order to make sure that I wouldn’t have to endure another war. It was a long and dangerous drive to Jordan, with the constant fear of knowing that if we were caught, it could possibly mean death. Today, it’s a journey millions of others are making in hopes of a brighter future and a safer home for their families.

When my family arrived in Jordan, I still remember the shock of losing everything that I had known. My friends, my extended family, our home, and practically every possession that we had. Even at a young age, I worried about what would happen to me and my parents, and where we would go from here. Due to our refugee status, it was difficult for us to attain many basic rights, such as employment and education. Multiple schools rejected my parents’ attempts to enroll me, as they did not want an Iraqi refugee as their student. Thankfully, one local principal decided to accept me as a student, so long as we agreed to keep my background a secret. Unfortunately, the other students soon found out who I was, and consequently, I became a target for daily beatings. This is the kind of stigma that many refugees carry when they leave their native countries. You’re constantly worried that someone will find out who you are, and you deflect anyone’s attempts to delve into your past. You feel that the only people you can trust are your family, and that is where your support comes from. Being stuck in virtual limbo, my parents and I held onto the hope that we would soon be accepted to a nation that would give us the opportunities that we dreamed of when we left Iraq. Thankfully, we were accepted into the United States for asylum, but for many of today’s refugees, a new homeland continues to remain out of reach.

Due to the masses currently fleeing Iraq and Syria, there is a renewed focus on the plight of refugees, but unfortunately their mental health needs continue to be overlooked, particularly for children. Their vulnerability leaves them susceptible to multiple forms of abuse, both physical and mental, and their situation is complicated by the fact that the sheer number of people often means that individual stories and struggles get lost in the crowd. Child psychiatry, though, can provide the interventions necessary for many of these young refugees who struggle with mental illness as a result of the trauma that they have endured. In order to do so, however, child and adolescent psychiatrists must better understand the unique plights that many young refugees experience and how to address certain nuisances within their own culture. What I hope to highlight are certain tips and approaches that can help mental health professionals better understand these unique experiences, and how to deal with certain obstacles to treatment, such as stigma.
Pre-Flight Experience: A Child’s Perspective

Firstly, an understanding of a young refugee’s trauma must begin with the initial portion of their journey, the pre-flight experience. In addition to warfare and loss of home, children must also deal with additional distress that is unique to them during this time period. Within middle eastern culture, especially in Syria, the extended family carries a special role as the primary social support for all the members within it. When anyone is in need, it is considered the duty of the extended family to provide care for these individuals. For young children, it also provides the primary social network in which they have been raised. Their friends, neighbors, and additional caretakers are usually just members of the extended family. During times of war, however, the extended family begins to break apart, as members leave sporadically for different locations. For children, this means the breakdown of the only social support that they have known, usually with no alternatives and without any clear understanding of why. Additionally, what can make a child refugee’s journey so difficult is the suddenness of it all. While the parents and other adults are consulted and aware of what is planned, children usually are not. They are given no chance to say goodbye to their loved ones or even an explanation as to what is happening. Subsequently, many children can find it hard to trust in their new home, as they are not sure when they might have to leave again.

Encampment

Due to the sheer number of families fleeing their homelands today, countries have set up encampments in an attempt to contain them until they can be resettled in more permanent locations. While these camps are designed to be temporary, millions end up spending years there. Unfortunately, a general lack of resources and abuse tends to define the experiences within them. In fact, data suggest that up to 82% of young girls within these camps face some form of abuse. Due to the lack of authority, however, many parents feel that there is no means to seek out justice for their children. Instead, they look to an early marriage to protect their daughters’ chastity and honor, as a quarter of all marriages within these camps involve girls younger than 18, with half marrying men 10 years their senior or older. The uncertainty of life within these camps can take a tremendous toll on the adults, as well. After escaping their native country, nearly a quarter of all parents feel that they have become too distressed to care for their own children. In order to avoid adding to that stress, many young refugees will avoid disclosing their own concerns and worries to their parents, choosing to internalize them, instead. These examples help highlight that while it may be tempting to focus on what drove a refugee to leave his or her homeland, mental health professionals must remember that much of the trauma that the refugee faces occurs after the escape, especially in these camps, and treatment plans must address this trauma early on.

In addition, child psychiatrists should be cognizant of the social environment for young refugees within these settings. While these countries have established schools in the camps, they have limited capacity, and up to half of all young refugees go without a formal education. Without school or their extended family, these children spend a crucial period of their young lives without a true social network. Consequently, when they arrive in their new western homelands, many suffer developmental delays and problems in school, such as disruptive behavior and a relatively high dropout rate. In order to treat the underlying cause of these issues, a great deal of trust must develop between these patients and their providers. Recently arrived refugees, however, can have a tough time trusting anyone in their new environment, including medical workers. To help overcome this barrier, mental health professionals should include the entire family in initial therapy, and as greater rapport is built, cater subsequent treatment to their young patients.

Stigma of Mental Care

A strong relationship will be instrumental in confronting the mental illnesses that many young refugees struggle with, in particular posttraumatic stress disorder (PTSD) and depression. About 45% arrive in the west with some PTSD symptoms, a condition that often presents with comorbid depression, especially in young girls.
Unfortunately, families can go months before seeking any psychiatric assistance for their children, mainly due to a perceived stigma that comes with mental health treatment. Thankfully, there are a number of techniques that can be used to overcome this obstacle. Firstly, refugee patients are more likely to follow psychiatric recommendations if mental health treatment is incorporated into greater medical care. Additionally, by establishing care in settings that are greatly respected by refugee populations, such as schools, and framing treatment as a means to improve school performance, refugees will be more likely to follow treatment plans. In fact, by using multiple settings in conjunction, mental health professionals can better avoid losing contact with their refugee patients.

Sensitive Topics
Young refugees arriving in the West have to balance two different cultures in order to appease their parents while avoiding ostracizing themselves from their new friends. Mental health professionals cannot be afraid to touch on these differences, as they may be a source of a large amount of stress. Within the home, young refugees also take on a different role for the family. Typically, it is the adults that explain culture to their children, but due to a lack of familiarity with their new homeland, many parents aren’t able to do this. Instead, by assimilating more quickly, the children essentially act as interpreters for the older members of their family. When something occurs that they don’t understand, the parents often times rely on their young children to place things into context for them. This added responsibility can be a great burden for a young child, and helps highlight the added pressure that psychiatrists should be aware of when treating a refugee family. By being around new views on religion, many young refugees may also find themselves questioning their faith for the first time. This can lead to friction with their parents or other young members of their family, and these patients may feel isolated as a result. By tackling these subjects early, individual or family therapy can be of great service to patients and help families better navigate their new surroundings. When taking a generally prophylactic approach, child psychiatrists can help prepare their patients for the likely challenges that they will face. For instance, even if a patient doesn’t report being bullied now, he or she will likely become a target for it in the future, and by training youth in how to use coping skills or contacting their school and preparing them, as well, a large difference can be made in the lives of these children.

Hope for a Generation
The aforementioned hurdles are based on experiences of past and recently arrived refugees, but as millions more seek asylum, new obstacles will likely arise as resources become even more limited. Due to their position, psychiatrists are well equipped to become advocates for many within this vulnerable population. In order to be effective, however, there must be a sincere effort to understand not only what drove refugees to leave their homeland, but the struggles that they have endured on their journey, and the challenges they are likely to face in the future. As a refugee, I know many who were never able to overcome what they suffered, and it has continued to haunt them into adulthood. As awareness grows, I have hope that the next generation of refugees will feel more comfortable seeking help, not only from a physical perspective, but a mental one, as well. By doing so, they will be better able to embrace their new homelands and lead more fulfilling lives.
**Take Home Summary**

- Child refugees face unique challenges when leaving their homeland, including the sudden loss of their social network, a lack of education within refugee camps, and being targets of abuse.
- Within their new homelands, child refugees must balance two different cultures and act as interpreters of their new surroundings for the older members of their family.
- Sensitive topics that should be brought up during treatment include feelings of guilt, frequent relocation, religion as a coping strategy, disconnection from the extended family, and the child refugee's role in the family.
- Greater familial involvement can be encouraged through family therapy, the use of multiple settings such as school and medical clinics, and framing treatment as a means to improve school performance.

**References**


**About the Author**

**Ishaq Lachin, BA**, is currently a fourth-year medical student at the Johns Hopkins University School of Medicine. He was raised in Chicago, IL, and graduated summa cum laude in political science with a minor in psychology from Loyola University Chicago. As a refugee from Iraq, Mr. Lachin strives to highlight the health challenges refugees face in their journey to a new homeland, especially in mental health.

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