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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.

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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.

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Seeking Clarity Within Complex Psychiatric Presentations

Michelle S. Horner, DO

Physicians are masters at simplifying. Indeed, one of the most salient skills within child and adolescent psychiatry is helping families sort through complexity to determine diagnosis and treatment planning. From the first day of residency, we are taught the value of a comprehensive yet concise psychiatric formulation – a highly focused summary resulting from hours of interviews, chart reviews, brainstorming, problem solving, and, of course, the gestalt from years of training and experience. This issue of JAACAP Connect highlights the many ways we distill complexity within the field of child and adolescent psychiatry.

Complexity within child and adolescent psychiatry is ever-broadening, as we advance our understanding of comorbidity, biological and environmental contributions, and individual variability, among other factors. In this issue of JAACAP Connect, complexity is demonstrated by Atluru and colleagues (p. 5), as they consider medical and psychiatric symptoms within the presentation of failure to thrive. The differential includes the recently defined avoidant/restrictive food intake disorder (ARFID), in which youth avoid food after an adverse eating event. The article reminds us of the importance of lifelong learning to expand our knowledge base.

Translating research into clinical care is complex, similarly requiring years of training and practice for successful mastery. This challenge inspired the primary mission of JAACAP Connect: “Promoting development of translational skills and publishing as education.” Although mentored publication experiences are critical for increasing competency in research literacy, limits in our time often mean that scientific journal reading starts and stops at the abstract. Andrés Martin, MD, MPH, editor-in-chief of JAACAP and JAACAP Connect’s first mentor, explains the key elements of the abstract for scientific publication (p. 19). This article is a must-read – as clinicians, we must recognize the purpose and limitations of the abstract, and as authors, the abstract is a window into the soul of the article.

In an era where schools and families push for quick fixes and rushed judgements, the importance of learning how to focus while considering everything cannot be underestimated. Chou and colleagues (p. 11) demonstrate how clinical vignettes can help students begin to recognize complex diagnoses, such as schizotypal personality disorders. The journey toward understanding often invokes personal reflection and motivation to help others. This awareness is articulated in our final two articles. Jacobi and Glowinski (p. 28) guide us through the history and controversies of foster care placement. Shapiro and colleagues (p. 22) convey the challenges of understanding and treating patients with traumatic brain injury and psychiatric comorbidity.

Clinicians filter volumes of patient information and research to determine what concepts to incorporate into diagnosis and treatment plans. The articles in this issue of JAACAP Connect remind us to slow down, consider the details, and extract the foundational elements to improve patient care – and to consider research and publication as a cornerstone for advancing our clinical skills and research literacy.

References
Introducing the New Editor of JAACAP Connect: Oliver M. Stroeh, MD

Dr. Stroeh, former associate editor of JAACAP Connect, takes the helm of the Connect ship with this issue from Founding Editor Michelle S. Horner, DO. Based in New York City, Dr. Stroeh is the Clarice Kestenbaum, MD, Assistant Professor of Education and Training in the Division of Child and Adolescent Psychiatry at the Columbia University College of Physicians and Surgeons and associate director of the NewYork-Presbyterian Hospital Child and Adolescent Psychiatry (CAP) Residency Training Program. His areas of interest include psychiatry training/education and psychotherapy.

Dr. Stroeh joined Connect as the John F. McDermott, MD, Assistant Editor-in-Residence in 2016. We are currently accepting applications for the 2018-2019 McDermott editor (deadline February 15th, 2017). For more information, please contact support@aacap.org.

Michelle S. Horner, DO, and Oliver M. Stroeh, MD, at AACAP’s 63rd Annual Meeting in New York, 2016.
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Failure to Thrive: Crohn’s Disease Presenting as Avoidant/Restrictive Food Intake Disorder (ARFID) in a Young Child

Aparna Atluru, MD, Jie Xu, MD, PhD, Carrie McAdams, MD, PhD

Abstract: Failure to thrive (FTT) is a state of insufficient nutritional intake that limits growth and development in children. FTT can be a diagnostic challenge for pediatricians. In the United States, FTT is prevalent in 5 to 10 percent of children in primary care settings. With a broad differential diagnosis causing FTT, including both organic and inorganic causes, pediatricians can have difficulty diagnosing and treating children with mixed etiologies. This report highlights how delays in obtaining the correct diagnoses and performing appropriate interventions can have significant consequences, including malnutrition, developmental delay, and psychosocial sequelae in a child. In this case, a child with FTT was initially diagnosed and treated for an inorganic cause, anorexia nervosa (AN), with an additional etiology of Crohn’s disease not recognized until several years of unsuccessful treatment for the AN. This report highlights the fact that behavioral and psychological components, including a fear of eating and refusal to try a variety of foods, may be consistent with a presentation of Crohn’s disease. It also emphasizes the need to continually re-evaluate diagnoses in young children, particularly when they are not responding to prescribed interventions.

Failure to thrive (FTT) can be a diagnostic challenge for pediatricians, who are typically the first clinicians to detect children suffering with this condition. FTT is a state of insufficient nutritional intake, which can be caused by inadequate caloric intake, inadequate caloric absorption, or excessive caloric expenditure. In the United States, FTT occurs in 5 to 10 percent of children in primary care settings. The differential diagnosis causing FTT can be very broad, including both organic and inorganic causes. However, this distinction can be insufficient, because many children have mixed etiologies. Delays in obtaining the correct diagnosis and performing appropriate interventions can have significant consequences, including malnutrition, developmental delay, and psychosocial sequelae. This report emphasizes the need to continually re-evaluate diagnosis in patients who are not responding to prescribed interventions. In the case below, a child with FTT was initially diagnosed with food phobia and anxiety by a primary care physician at the age of 6. Subsequent evaluations by different specialists led to the diagnosis of an inorganic FTT, which was labeled as an eating disorder at age 8. Despite follow-up with psychiatrists, nutritionists, and other specialists, the patient maintained treatment-resistant iron-deficiency anemia, short stature, and pubertal delay. After an acceleration of weight loss at age 11 led to multiple medical hospitalizations, subsequent medical work-ups resulted in a diagnosis of Crohn’s disease complicated by food-aversion secondary to anxiety.

Case

“Emma” is an 11-year-old female with history of microcytic anemia, short stature, weight loss, FTT, and a diagnosis of AN made at 6 years old by her primary care physician (PCP). Her mother had a normal pregnancy without any complications. She was a full-term baby with a birth weight of 3.63 kgs (8 lbs). Up to 5 years of age, Emma’s developmental history was normal, and she met all her developmental milestones appropriately.

Emma’s issues with food started very suddenly. She developed an aversion to solid food textures around 6 years of age. This was acute in onset and quickly grew into a fear of swallowing. Emma’s peers teased her about the possibility that her teeth would fall out, which exacerbated her symptoms. She became extremely selective in her diet, to the point of only consuming chocolate milk, approxi-
Failure to Thrive: Crohn’s Disease

Marnie, a 12-year-old girl, presented to our facility with a history of failure to thrive for several years. She was originally diagnosed with Crohn’s disease at the age of 6 years and 3 months. Her family initially attributed her symptoms to a possible eating disorder in their daughter. They took her to her pediatrician for a medical evaluation, who found that her height and weight had fallen below the third percentile (Figure 1). These measures in height and weight met criteria for FTT. Emma’s diagnosis was unusual in that most children with FTT typically present at much younger ages.

Subsequently, her pediatrician started a medical work-up for FTT, including an upper gastrointestinal endoscopic exam and basic blood work to evaluate her electrolytes and blood cells. The upper endoscopy revealed that Emma had a diverticulum in her distal esophagus. However, this finding was considered insufficient to explain Emma’s FTT diagnosis. She was further referred to hematology/oncology for evaluation of anemia. The hematology-oncologists diagnosed iron-deficiency anemia and started Emma on ferrous sulfate supplements. A dietitian was consulted to assist with Emma’s eating phobia.

Despite these interventions, Emma did not improve. Her weight and height remained below the 3rd percentile. When she was nearly 8 years old, bone x-rays indicated her bone age was 2 years below her chronological age. Her developmental pediatrician classified her issues with food as a feeding disorder of infancy/early childhood of nonorganic origin by age 8. At this time, Emma also started seeing a psychiatrist who diagnosed an avoidant/restrictive food intake disorder (ARFID). The psychiatrist suggested Emma try an inpatient eating disorders facility, but the family declined. She continued to prefer soft and liquid foods, and her anemia worsened, despite oral iron supplementation (Figure 2), leading to hospital visits for blood transfusions. Despite these active medical issues, Emma continued to excel academically in school.

At the time of presentation to our facility, Emma was 11 years and 3 months old chronologically, but her bone age was 6 years and 10 months. Shortly before admission, Emma lost 6.8 kgs (15 lbs) in 3 days following an episode of unremitting diarrhea. Emma was admitted to the hospital, tested positive for parvovirus, and received two blood transfusions. Emma had often noted pain after she ate, but denied any emesis, diarrhea, or greasy stools. After discharge, she continued to see her primary care physician on a weekly basis for weight checks, but failed to recover the lost weight, and began losing weight again, with a loss of 0.68 kgs (1.5 lbs) in a week and a half following discharge. At this time, the primary care physician recommended admission to an eating disorders unit. Her family agreed, and brought her to the ER to obtain medical clearance prior to admission to a psychiatric eating disorders program.

Given Emma’s second presentation to our hospital without significant improvement in her weight within a
month, physicians began to consider the possibility that Emma had an underlying undiagnosed medical condition. Detailed physical exam revealed clubbing of the nails and trouble breathing. Placing these findings in the context of her poor growth and weight gain, the physicians began a full workup for cystic fibrosis (CF). CF testing was conducted, including cystic fibrosis transmembrane conductance regulator (CFTR) mutation testing, sweat chloride test, pulmonary function testing, chest CT, and colonoscopy. The pulmonary function tests were normal, and the sweat test was negative. However, the colonoscopy revealed intestinal abnormalities, including aphthous ulcers, cobblestoning, and discontinuous lesions in the large intestine. These findings were consistent with inflammatory bowel disease, and the specific diagnosis of Crohn’s disease was established.

The diagnosis of Crohn’s enabled Emma to begin treatment for the underlying medical cause of FTT. Emma was started on nasogastric tube feeds, with labs conducted and followed throughout admission to ensure that refeeding syndrome did not develop. Refeeding syndrome is a disorder that consists of metabolic abnormalities when a severely malnourished person begins to eat again. Refeeding increases the basal metabolic rate, leading to decreases in serum electrolytes such as phosphate, potassium, and magnesium. Glucose and thiamine may also decrease. Cardiac arrhythmias can result from this illness, with other significant risks including confusion, coma, convulsions, and cardiac failure. Emma’s hospital course was further complicated by pneumoperitoneum and peritonitis. After perforation was found in her sigmoid colon, a resection and colostomy were done. At this point, Emma was placed on infliximab, continued with nasogastric tube feeds of a nutritional shake and total parenteral nutrition, and began trying to consume regular meals.

Throughout the hospital course, Emma continued to show considerable anxiety towards food. She feared choking on large pieces of food. She reported abdominal pain intermittently, particularly following meals and relieved with bowel movements. Psychiatric consultation was obtained due to the patient’s anxiety related to meals. However, the patient’s family felt that psychiatric treatment had contributed to Emma’s anxiety, and wanted to focus on resolving the now-identified medical issues resulting from Crohn’s disease.

Emma had several hurdles to overcome prior to discharge. Psychiatry services recommended a trial of lorazepam to help with anxiety, but Emma did not tolerate the medication, reporting flushing and increased anxiety. Hydroxyzine was offered on as-needed basis, but the patient did not try the medication during her hospitalization. Psychology and psychiatry services continued to follow Emma, and recommended discharge into an intensive outpatient eating disorders program. However, the eating disorders program was located far from the family’s hometown and they considered attending the program to be a hardship, and unnecessary given the medical diagnosis and treatment for Crohn’s disease. Emma began eating a larger portion of her meals. When Emma could consume 50% of her meals in addition to nasogastric tube feeds, discharge was permitted. Psychiatry services recommended that if at subsequent visits to the gastroenterology clinic Emma was unable to maintain and gain weight, eating disorders treatment would facilitate normalization of the avoidance and restrictive pattern she had developed.

The patient is currently 12 years and 9 months old. Since her presentation to the hospital, her colostomy has been re-anastomosed, allowing restoration of bowel function. The patient continues to be on a medication regimen to treat her Crohn’s disease, notably infliximab infusions every 8 weeks, cyproheptadine, esomeprazole, and dietary supplementation. The patient’s overall health is improving, as evidenced by an X-ray bone age of 10 at 12 years of age. Although Emma’s bone age is delayed, it has advanced significantly in a year’s time. Her predicted height is 4’9, assuming that she continues to grow well and her bone age does not continue to advance rapidly. At 12 years and 6 months of age, her weight was 26 kgs (57 lbs), which puts her at the 5th percentile for weight.
Failure to Thrive: Crohn’s Disease

Discussion

This case report highlights a complex presentation of symptoms in a young child, including gastrointestinal discomfort, food aversion, anxiety, and excessive weight loss. In children, gastrointestinal symptoms can have a variety of medical and psychiatric etiologies. Child and adolescent psychiatrists are well-versed in recognizing these symptoms in young children suffering from neurodevelopmental, somatoform, anxiety, and eating disorders. Both AN and Crohn’s disease can result in growth retardation, weight loss, and gastrointestinal symptoms that include abdominal pain, diarrhea, constipation, and vomiting (Table 1). Avoidant/restrictive food intake disorder (ARFID) is a recently defined condition, which consists of a prolonged disturbance in eating that leads to symptoms such as weight loss or inadequate growth and/or impaired psychosocial issues, such as an inability to eat with others.4 ARFID and AN both present with similar general medical symptoms: anemia, fatigue, and bradycardia. Gastrointestinal symptoms in AN and ARFID are somewhat similar and include abdominal pain. However, they differ in that children with ARFID often develop a reluctance to eat food following an eating-related adverse event, and avoid foods based on sensory qualities, such as texture, color, taste, or temperature.4 For example, children may develop a fear of swallowing following a frightening episode of gagging; choking or vomiting may be diagnosed with ARFID. These factors were consistent with Emma. In contrast, children with AN often initially choose to limit food intake because of concerns about weight, calories, health, or body appearance.4 Emma did not show these concerns, and as such, a diagnosis of ARFID is a better fit for her symptoms.

Crohn’s disease is an inflammatory disease of the intestine that also includes gastrointestinal and weight loss symptoms and can mimic an eating disorder.5 Given that psychiatric disorders associated with gastrointestinal symptoms are more common in this age group than is Crohn’s disease, the diagnostic difficulty in our case was very high. While the lifetime prevalence of anorexia nervosa is 0.9% in women,6 the incidence of inflammatory bowel disease is only 7 per 10,000 children.5 In addition, FTT is typically diagnosed in children before 3 years of age, with multiple causes stemming from aberrances related to the development of the gastrointestinal tract.1 These causes vary extensively, and include problems of chronic diarrhea to genetic malabsorption syndromes.1 Organic work-up for FTT often includes initial lab testing to evaluate for electrolyte, hematologic, and thyroid abnormalities.7 Importantly, our patient showed normal development until 5 years of age, which is unusual for patients with FTT. This aspect of the presentation may have puzzled clinicians and supported a theory related to a psychiatric or acquired behavioral problem surrounding food consumption. Similarly, the report to the PCP that siblings teased her about her food behavior might also reinforce an idea of an inorganic etiology.

In retrospective review of Emma’s case, there are several items that suggested an inflammatory bowel disease such as Crohn’s disease. Patients with Crohn’s disease can present with a variety of symptoms, including aphthous mouth ulcers, anemia, iron deficiency, and folate and vitamin B12 deficiencies, as well as elevated lab tests that include erythrocyte sedimentation rate (ESR), white blood cell and platelet cell counts, and C reactive protein (Table 1). Emma had a microcytic anemia resistant to iron treatment, suggesting an organic cause related to absorption. It takes the body about 120 days to generate healthy red blood cells,1 but our patient did not respond within this period despite reporting medication compliance, and instead required multiple transfusions. This finding is suggestive of an organic factor interfering with iron absorption. In contrast, patients with AN often show excessive concern about weight, self-induced vomiting and other purging behaviors, bradycardia, lanugo hair, and amenorrhea (Table 1). Emma lacked overt concerns related to her weight and shape, instead reporting difficulty and pain related to eating.

The differential diagnosis of FTT can be very broad, is often categorized into organic and inorganic causes, but many children can have mixed etiologies. This was the case with Emma for over half of her life.2 Interestingly, psychological factors have also been associated with Crohn’s disease, including depression and low
Studies suggest that patients with Crohn’s disease have increased rates of depressive and anxiety symptoms compared with healthy controls of the same age. When patients with undiagnosed Crohn’s disease present with prominent mood and anxiety symptoms, abdominal symptoms are often more likely to be attributed to psychiatric rather than organic causes, including somatization. This report, along with these studies, highlights the importance of frequent reappraisal of the working diagnosis when treating children with FTT, with consideration for both organic and inorganic causes.

Table 1. Symptoms Observed in Failure to Thrive, Anorexia Nervosa (AN)/Avoidant Restrictive Food Intake Disorder (ARFID), and Crohn’s Disease

<table>
<thead>
<tr>
<th></th>
<th>Failure to Thrive</th>
<th>Symptoms of AN, Restricting Type and ARFID</th>
<th>Crohn’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Symptoms</td>
<td>Growth retardation</td>
<td>Both AN and ARFID</td>
<td>Mouth ulcers, anemia, iron deficiency, B12 and folate deficiency, elevated ESR, elevated WBC, elevated platelets, raised C reactive protein</td>
</tr>
<tr>
<td>Specific GI Symptoms</td>
<td>Difficulty feeding</td>
<td>BOTH</td>
<td>Diarrhea, constipation, abdominal pain</td>
</tr>
<tr>
<td>Common Psychiatric Symptoms</td>
<td>Fatigue</td>
<td>AN</td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ARFID</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>

Note: ESR = erythrocyte sedimentation rate; GI = gastro-intestinal; WBC = white blood cells. *Characteristics of AN inconsistent with ARFID.

**Conclusion**

The above case can serve to remind clinicians to closely consider organic etiologies of unexplained abdominal symptoms in school-age children in concert with the inorganic considerations. A disease process such as Crohn’s, which is more common in teens and adults, should not completely be excluded from the differential, simply because it is statistically and demographically less likely in children. In addition, psychological symptoms should not point clinicians completely away from organic differentials, and should instead become a focus of additional clinical attention. A team approach...
with both medical and psychiatric input in the treatment of young patients, and frequent reassessments when treatments are not effective, may improve care and accelerate the determination of the correct diagnosis and provisioning of optimal care. Finally, while Crohn’s disease may have resulted in the disordered patterns of food consumption observed in Emma, throughout her hospital stay, she continued to show psychological and behavioral challenges related to eating. By providing her with the behavioral treatments developed for ARFID in concert with the management of her Crohn’s disease, she is likely to have the best outcomes.

**Take Home Summary**

Missing the correct diagnoses and appropriate interventions can have significant consequences in a child’s development. This case exemplifies how behavioral and psychological components of food consumption may also be consistent with a presentation of Crohn’s disease. There is a need to continually re-evaluate diagnoses in young children, particularly when they are not responding to prescribed interventions.

**References**


**About the Authors**

Aparna Atluru, MD, is a child and adolescent psychiatry fellow at Stanford University.

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**Disclosure:** Drs. Atluru, Xu, and McAdams report no biomedical conflicts of interest or potential conflicts of interest.

The authors would like to thank the patient and her family for agreeing to publication of their story, and providing necessary details about the illness and treatment. The authors thank Dr. Jane Miles for assistance and encouragement in pursuing this project.
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Educating Medical Students on Adolescent Schizotypal Personality Disorders

Shinnyi Chou, BA, Charles Albert Whitmore, MD, MPH, Gautam Rajendran, MD

Personality disorders are particularly subtle and complex, and often present a challenge in medical student education. On one hand, there are critical differentials to consider when determining primary versus secondary diagnoses, and individual personality traits may greatly alter treatment approaches of various major psychiatric disorders. On the other hand, educators are constantly faced with the risk of students resting on the laurels of overgeneralization, approaching every patient on the disorder spectrum as an extreme personality type.

Utilization of Case Vignettes

One of the most common methods of educating clerkship students is through the use of case vignettes. Vignettes provide students with a sense of immediacy and urgency—that these real-life examples represent patients they will soon encounter and should understand in order to provide appropriate care. Case vignettes may also help emphasize the importance of deciphering symptoms through a global, birds-eye view, as real-life patients almost never present according to the textbook definitions. This allows students a chance to utilize their critical analytical skills to reach an assessment, hence practicing the real art of medicine beyond the strict memorization of diagnostic criteria. Here, we present a vignette of an adolescent with schizotypal personality disorder (SPD), in hopes that readers will reflect on the case description as the specifics of the disorder are explored.

Case Vignette

Jenny (whose name and identifying information have been altered to preserve anonymity) is a fourteen-year-old girl with a history of depression and anxiety who was admitted to the adolescent inpatient psychiatric unit due to suicidal ideation with the plan to smash a lightbulb against her head, and homicidal ideation without specific targets. Parents described Jenny as a happy child with a vivid imagination and fantastical thinking, at times believing she was a dragon with scales on her body, but who became “moody” with the onset of puberty. The family moved from an overseas military base back to the United States a year prior to admission, and four months prior to admission, Jenny began expressing feelings of depressed mood with self-harm ideations after being teased by boys in her class. Since then she has been repeatedly hospitalized and sees a therapist regularly, and has been given trials of fluoxetine and risperidone. During the past four months, Jenny also frequently endorsed preoccupations with cannibalism in addition to suicidal ideations. Other self-reports include abilities of telepathy, superhuman vision, being able to “erase” people with the help of her group of telepathic “teammates,” participation in homicidal acts on random targets, as well as feeling different than same-age peers, stating “nobody understands me.” While recognizing the odd nature of her beliefs, Jenny appeared undisturbed by them. On admission, she stated that “[I] deserve to die,” that “my family is better off without me,” and that “I cause all the problems.” Parental and self-reported social history also suggests a young girl without close and enduring relationships. In addition, family is undergoing the stress of a newly diagnosed terminal illness among one of Jenny’s caretakers (her father). Jenny has requested voluntary hospitalization during past episodes of suicidal ideation. During her interactions with inpatient staff, she appeared coherent and euthymic, though somewhat withdrawn, with occasional inappropriate affect while discussing her bizarre preoccupations.
Definition

Personality may be described as the combination of emotional knowledge gathered through life experiences, or the ability of an individual to regulate cognition and hence behaviors in response to environmental inputs. Certain basic emotions, such as interest, are present at birth, while others develop gradually within the first two years of life. Personality disorders may then be thought of as an impairment of these basic regulatory systems that leads to individual dysfunctions within society. In recent years, the idea of early life prodromal symptoms leading to adulthood personality disorder diagnoses has led to increased attention to adolescent personality disorders. It is well known that, in regards to childhood behavioral problems, the classification typically involves internalizing or externalizing reactivity of the child. Thus, it is believed that the appearance of adolescent personality disorders is the result of these early experiential interpretations, in combination with other biopsychosocial risk factors, leading to habitual emotional responses. Specifically, schizotypal personality disorder (SPD) is a unique disorder that may be argued as an endophenotype within the spectrum of psychotic disorders. In fact, the DSM-5 categorizes it within the schizophrenia spectrum disorders, and includes a specifier diagnosis of “SPD premorbid” for patients that present with a history of SPD prior to a diagnosis of schizophrenia. In one study, the heritability of SPD was estimated to be as high as 72%. Beyond genetic risks, increasing evidence points to brain structural and functional abnormalities in patients with SPD. For example, recent magnetic resonance imaging data have found that reduced gray matter (GM) in the left middle temporal gyrus in males was associated with cognitive disorganization/impulsivity and unusual sensory perceptions/magical thinking (SPMT), while reduced GM in the caudate in females was associated with SPMT, and reduced GM in the left amygdala and hippocampus was associated with social anxiety/withdrawal. In our vignette, the patient was found to have multiple family members with alcoholism and one cousin with bipolar disorder, indicating that the patient may have increased genetic susceptibility toward psychiatric disorders.

Psychological Factors

The genetic and brain anomalies in SPD largely contribute to negative symptoms such as apathy, while other evidence supports the correlation between a history of abuse and the presence of positive SPD symptoms. Trauma (e.g., physical, emotional, sexual abuse, and neglect) seems to increase the risk of developing SPD, and the patient’s perception of these experiences influences the magnitude of their effects. One large meta-analysis identified the odds ratio for SPD as 1.62-5.84 with history of physical abuse, 1.35-6.70 with neglect, and 2.05-4.15 with sexual abuse. In addition, one of the prominent theories of personality disorder development remains problematic parental attachment in early childhood. On this subject, SPD is associated with dismissing attachment, disorganized attachment, and high avoidance attachment. For our patient, Jenny, there was no evidence of trauma history. However, in examining her early childhood social history, Jenny’s family relocated frequently due to government careers, and one might conjecture some emotional trauma due to the lack of stable peer relationships. In addition, Jenny’s family relationships were stoic, rigid, and rulebound, rather than warm, engaging, and playful. Furthermore, the patient’s recent negative interactions with peers seemed to have contributed to her mood lability.

Risk Factors and Predictors

Biological Factors

Evidence suggests significant similarities between the biological characteristics of schizophrenia and SPD. For example, similar phenomenological impairments in eye tracking can be seen in both patients with schizophrenia and SPD. In addition, similar genetic polymorphisms, such as that in the gene encoding dopamine 2 receptor, are found in both populations. Interestingly, SPD is also found at higher rates in family members of patients with schizophrenia, suggesting a common genetic susceptibility. Indeed, in one study, the heritability of SPD was estimated to be as high as 72%. Beyond genetic risks, increasing evidence points to brain structural and functional abnormalities in patients with SPD. For example, recent magnetic resonance imaging data have found that reduced gray matter (GM) in the left middle temporal gyrus in males was associated with cognitive disorganization/impulsivity and unusual sensory perceptions/magical thinking (SPMT), while reduced GM in the caudate in females was associated with SPMT, and reduced GM in the left amygdala and hippocampus was associated with social anxiety/withdrawal. In our vignette, the patient was found to have multiple family members with alcoholism and one cousin with bipolar disorder, indicating that the patient may have increased genetic susceptibility toward psychiatric disorders.
Social Factors
The most commonly identified social risk factor for developing SPD symptoms is low socioeconomic status, specifically that of the patient’s family of origin. Other less common social factors associated with SPD include religiosity, with one recent study showing intrinsic religiosity (i.e., religion as an end in itself) to be associated with decreased risk of developing SPD, while religious experience and extrinsic religiosity (i.e., religion as a means to an end) increased schizotypy. Recently, research examining the association between creativity and SPD also suggests the contribution of cultural factors in shaping the perception of SPD as a psychopathology or social norm (i.e., creativity), which, while not directly affecting the risk of SPD development, speaks to the role of culture in social support and acceptance. In the present case, the patient grew up in a stable, middle-income family. However, she is experiencing the recent social stressor of her father’s newly diagnosed, potentially terminal illness, something especially difficult for her since her father has been the stay-at-home caregiver while her mother is at work. In addition, Jenny appears to have been socially ostracized and rejected by her peers both in the past and during the current geographic relocation.

Diagnosis
Differential Diagnoses
Differential diagnoses of SPD include, but are not limited to, schizophrenia spectrum disorders (i.e., schizophrenia, schizoaffective, schizophreniform, and schizoid personality disorders), anxiety and trauma disorders, bipolar disorder and other mood disorders with psychotic features, and other personality disorders, especially avoidant, paranoid, and borderline personality disorders. In assessing our patient, Jenny, we confirmed that the odd beliefs were not associated with other symptoms of mania, and that she had no overt disorganized thought content or negative affect suggestive of psychosis. Jenny did meet criteria for major depressive disorder, as well as generalized anxiety disorder, in addition to the suspected SPD, which can be comorbid in patients with SPD.

DSM-5 and ICD-10 Definitions
According to DSM-5 criteria, diagnosis of SPD requires significant impairments in personality functioning manifested by impaired self-functioning and interpersonal functioning, as well as pathological personality traits manifested in psychoticism, detachment, and negative affect. It is important to note that the ICD-10 classifies SPD (named schizotypal disorder) as a clinical disorder rather than a personality disorder, describing it as symptoms that “resemble those seen in schizophrenia.” However, the listed disturbances largely echo those in DSM-5. In assessing Jenny, her symptoms were congruent with the diagnosis of SPD according to both DSM-5 and ICD-10.

Personality Assessments
Various multidimensional constructs exist for modeling SPD, including two-factor (perceptual and interpersonal deficit), three-factor (with disorganization), four-factor (with impulsivity), and five-factor (with social anxiety and social anhedonia) models. Irrespective of the model used, many well-validated personality measurement scales may help assess for symptoms of SPD in adolescent patients. Some of these are listed below. Each questionnaire is associated with unique strengths and weaknesses, and are easily accessible for use. As a case sample, we administered the Rust Inventory for Jenny. She scored an 8 on the scale of 1-9 transformed from the raw score, approximately corresponding to the top 8.5% of the population in terms of tendency toward magical thinking and unusual perceptual/sensory experiences. This is interpreted as having a very high likelihood of having a diagnosis of SPD according to the Inventory. The following is a list of measures that can be used to explore personality and SPD:

- Coolidge Personality and Neuropsychosocial Inventory for Children
- Diagnostic Interview for Genetic Studies Modified Structured Interview for Schizotypy
- Dimensional Assessment of Personality Problems
- Dimensional Personality Symptom Item Pool
- Psychiatric and Schizotypal Inventory for Children
Adolescent Schizotypal Personality Disorders

- Rust Inventory of Schizotypal Cognition
- Schedler Wester Assessment Procedure-200 for Adolescents
- Schizotypal Personality Questionnaire

Family, Social, and Developmental History
As mentioned in the previous section, the risk of SPD is multifactorial and includes genetic, psychological, and social variables. Thus, it is critical for students to perform a detailed psychiatric interview in order to identify the presence or absence of the aforementioned risk factors, which may act as collateral evidence in the final determination of the patient’s disorder. In addition, while the various measurement tools may be able to identify core social and emotional traits at the time the patient completes the questionnaire, episodes of irrationality, poor social interactions, hypersensitivity, fantastical thinking, or detachment that occurred during early childhood may be best elucidated from family member accounts. In the case of our patient, Jenny, her teasing by peers may be an indicator of dysfunctional social interactions secondary to eccentricity, and warrant further investigation.

Treatment
Pharmacological Treatment
Due to the similarity in biological origins of schizophrenia and SPD, similar pharmacological treatments as those used for schizophrenia have been employed to manage the symptoms of SPD, namely antipsychotics. Specifically, atypical antipsychotics such as risperidone have been shown to be effective in reducing symptom severity in SPD. However, there are reasonable concerns regarding the use of atypical antipsychotics for treatment of positive symptoms in SPD. Due to the nature of these “organized” delusion-like symptoms that may be more appropriately labeled as “bizarre” or “odd” beliefs, patients may be subjected to escalating doses of medications without signs of improvement. This lack of benefit may then expose patients to unnecessary medication-induced adverse effects. In instances where patients present with fewer symptoms of perceptual or sensory disturbances and more of rumination and social anxiety, trials of selective serotonin reuptake inhibitors (SSRIs) such as sertraline may be more appropriate.

Therapy
SPD is particularly difficult to treat with therapy due to patients’ paranoid tendencies hindering the development of a therapeutic alliance. It may be slow and painstaking, often requiring a long-term commitment on the part of the clinician. In general, initial supportive therapy is necessary for patients with severe impairments in order to improve activities of daily living. This can be followed by individual and cognitive-behavioral therapy including problem-solving skills and cognitive restructuring. Clinical data also indicate an increased success in symptom improvement with simultaneous family therapy. It is suggested that only when patients develop sufficient insight and correct interpretation of social interactions should they begin a trial of group therapy.

Prognosis
Common Comorbidities
Most patients with SPD will not develop full psychosis or progress to schizophrenia. However, SPD does show high comorbidity with several other psychiatric disorders, with one study suggesting bipolar disorder types 1 (22.3%) and 2 (5.1%), major depressive disorder (15.5%), social (19.4%) and specific (25.6%) phobias, posttraumatic stress disorder (29.6%), generalized anxiety disorder (20.0%), substance use disorder (31.1% for nicotine dependence and 20.6% for any alcohol use disorder), and borderline (odds ratio 26.5) and narcissistic (odds ratio 13.6) personality disorders.

Progression to Other Disorders
While adolescent SPD has been shown to predict the later onset of primary psychiatric diagnoses such as major depressive disorder, it is also important to keep in mind the reciprocal relationship between primary psychiatric diagnosis and personality disorders. For example, it is possible for early diagnoses of primary
psychiatric illnesses to predict the adulthood onset of personality disorders.28

**Adulthood Functionality**

Most researchers agree that personality traits may be fluid throughout development into adulthood. Thus, in some adolescents with SPD, the symptoms may resolve as patients progress through different social environments and life stressors. However, evidence also suggests that different dimensions of an individual’s personality display various degrees of stability. For example, in a study of patients with SPD over a two-year period, the most prevalent and least changeable phenotypes were paranoid ideation and unusual experiences, while the least prevalent and most changeable were odd behavior and constricted affect.29 The authors further concluded from the results that the symptoms most likely to remain are those associated with attitudes and belief systems, while those likely to improve are associated with external behaviors and reactivity. In general, however, adolescent SPD is associated with myriad negative long-term effects, including high familial conflict during adulthood transition (i.e., ages 17 to 27), as well as a decreased adulthood quality of life.4

**Conclusion of Case Vignette**

After admission for the most recent episode of suicidal and homicidal ideation, Jenny’s risperidone dosage was adjusted to target her psychotic symptoms of auditory and visual hallucinations, as well as delusions of homicidal activities. She also participated in inpatient group therapies, as well as a few sessions of family therapy. She was discharged to the partial hospitalization program after 12 days of inpatient care. At discharge, patient denied suicidal and homicidal ideations, but did endorse persistent, though reduced, frequency of visual hallucinations and telepathic thoughts. Patient did experience mild extrapyramidal effects from risperidone, with the highest abnormal involuntary movement scale score being 3. For the side effects, she was given 0.5 mg of benztropin twice per day along with the 1.5 mg of risperidone at bedtime and 30 mg of fluoxetine daily.

In the partial hospitalization program, Jenny’s condition remained stable. She continued to report personal beliefs consistent with SPD traits during interviews, including experience of seeing ghosts, preference for dark spaces, distrust of others, feeling misunderstood, and believing that dragons provide her protection and confidence. An interesting aspect of Jenny’s case is that, in agreement with studies of SPD comorbidities, she has symptoms suggestive of anxiety- and depression-related disorders. These symptoms initially dominated the patient’s presentation, resulting in a delayed unmasking of the underlying SPD symptoms that contribute to and exacerbate the other diagnoses.

**Conclusion**

By using Jenny’s case to discuss adolescent SPD, the current work encourages medical student educators to engage students in the general discussion of understanding personality disorders. A basic assessment and treatment flow chart is included with this text (Figure 1) to serve as an educational tool for students. We hope that educators will challenge the hesitancy of, and concerns with, diagnosing adolescent populations with personality disorders. A recent article addressing some of the common obstacles eloquently dispelled many of the myths surrounding proper assessment and treatment of adolescent personality disorders.30 We also hope that the case vignette may provide educators with some questions for students to consider in adolescent SPD. For example, might there be adverse effects or inaccurate score results with the use of personality questionnaires in this age group? How might the process of normal identity development interact with the odd beliefs and eccentric themes? In addition, prompting students to think of the risks and benefits of antipsychotic use in the treatment of SPD would not only enhance pharmacology understanding but also best practice recommendations. In sum, it is ultimately for the benefit of the adolescent to receive a proper diagnosis and treatment plan, and care must be undertaken to fairly and accurately assess the patient through gathering as much evidence as necessary to make a sound judgment.
## Adolescent Schizotypal Personality Disorders

### Figure 1. Basic assessment and treatment flow chart for adolescents with suspected schizotypal personality disorders.

**Suspect schizotypal personality d/o?**
- Unusual sensory/perceptual experiences
- Magical thinking
- Social anxiety/withdrawal

**Safety check:**
- Neglect/abuse
- Suicidal/homicidal thoughts/plans

**Consider comorbidity and differentials:**
- Anxiety-related disorders/phobias
- Bipolar disorder type 1 and 2
- Borderline/narcissistic personality disorder
- Schizophrenia/schizoaffective disorder
- Schizophreniform disorder
- Schizoid personality disorder

**Diagnosis:**
- Initial management – Rule out medical/substance etiology
  - CBC, CMP, TSH/T4, UA, urine toxicology, fasting lipids
  - DSM-5 diagnostic criteria
  - Consider family and developmental history
  - Personality disorder screening tools
    - Dimensional Personality Symptom
    - Psychiatric and Schizotypal Inventory for Children
    - Rust Inventory of Schizotypal Cognition
    - Schizotypal Personality Questionnaire

**Medications:**
- May be appropriate for management of positive symptoms (i.e., hallucinations)
- May be required for addressing comorbidities (i.e., anxiety or bipolar disorders)
- Positive symptoms (perceptual/sensory disturbance) – Consider antipsychotics
- Social anxiety – Consider SSRIs

**Therapy:**
- Supportive therapy
- Individual and family therapy
- Cognitive-behavioral therapy
- Group therapy
- Substance use interventions

**Education:**
- Family psychoeducation
- School support

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*Note: CBC = complete blood count; CMP = complex metabolic panel; d/o = disorder; SSRI = selective serotonin reuptake inhibitor; TSH/T4 = thyroid stimulating hormone/free T-4; UA = urinalysis.*
**Take Home Summary**

Personality disorders can be diagnosed and treated during adolescence but are often subtle and complex. Case vignettes can be helpful educational tools for engaging trainees’ critical thinking skills and teaching the nuances of personality disorders during adolescence.

**References**


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**JAACAP February Issue — Available Now!**

Orpheus and Eurydice, the Fall of Troy, the birth of Dionysus: these and some 247 other myths and stories of transformation are told in Ovid’s epic, the Metamorphoses. The poet writes of women becoming bears (Callisto), hunters becoming the hunted (Actaeon), and daughters becoming sons (Iphis and Lanthe). Neither the stories nor the style originated from Ovid; he drew on the rich tradition of Greek metamorphosis poetry, which used the theme of transformation to comment on, among other subjects, tensions in society between expectations and reality. In this issue, Mental Health and Self-Worth in Socially-Transitioned Transgender Youth, by Durwood and colleagues, presents research on a population in the midst of transformation: socially transitioned transgender youth, who represent themselves as members of the opposite gender in everyday life. These individuals report rates of depression similar to their same-age peers and only slightly higher rates of anxiety. While not much research has examined the wellbeing of socially transitioned transgender youth, this article points to metamorphosis to slacken the tension between natal sex and asserted gender.
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Abstract Art: Twelve Tips to Help You Write an Effective Abstract

Andrés Martin, MD, MPH

I’m sorry I wrote you such a long letter; I didn’t have time to write a short one.

– Blaise Pascal

Abstract

Background: The abstract is a core component of any scientific publication. Despite its importance, the abstract is often overlooked or hastily written shortly before submission, thus thwarting the work’s chances of being initially reviewed or eventually discovered.

Method: Based on my experience as editor-in-chief of the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), I: 1) Provide rates of abstract-related rejection decisions; and 2) Articulate high-yield strategies to improve the quality of abstracts submitted to scholarly journals or professional society meetings.

Results: During the five-year period ending in December 2015, 2,764 original research articles were submitted to the Journal. Of these, 1,680 (61%) were rejected unreviewed. Reasons behind these rejections fell into three broad categories, in similar proportions: 1) Poor content fit (32% of those submissions rejected unreviewed); 2) Methodological limitations (33%); and 3) Poor abstract quality (35%). Common problems identified in poor quality abstracts included: vague or insufficiently descriptive titles; unclear content demarcation between, or diffusion across, different subsections; insufficient or excessive methodological or numerical detail; failure to encompass core epidemiological principles; interpretation that went beyond the data; editorializing; and substantial grammatical, language usage, or typographical errors.

Conclusion: Abstracts can be enhanced by incorporating the dozen strategies described. High-quality abstracts increase the likelihood of a submission being reviewed rather than summarily rejected, and of a published work being eventually discovered and reaching its intended audience.

Key words: Abstract, publication, scholarly journal, education, bibliometrics.

Let’s begin by considering the “job description” of an abstract. An abstract is the scholarly equivalent of an elevator pitch. First, it should contain key content and take-home points. Second, it should effectively open doors: those toward publication, presentation at a conference, or discovery in a database. Third, it should provide the basic infrastructure on which to build a poster, article, or oral presentation. In this article I propose twelve practical steps to maximize the efficiency, effectiveness, and accuracy of your pitch.

1. Whatever else you do, start with your abstract

Don’t ever leave your abstract to the end of your writing: by that point, it is too late to get it—and, potentially, your larger work—right. This does not mean that your abstract needs to be airtight before you set out to complete your work. Rather, it is an invitation to undergird your construction correctly from the beginning. To get into the right mindset, think of an abstract as scaffolding, not ornamentation: even while numbers and exact details are still pending, an abstract should frame the core of your story.

2. Respect the demarcation between the abstract’s subsections

Lay out the formulaic subsections and fill them in with what you have on hand, not fretting (yet) about what you are missing. The objective makes the case for what you are aiming to address and why the question is worth asking. Consider a line or two (but no more) about context and background. Include no instruments or
details in this subsection. Under **method** describe how you went about addressing the question; don’t include any numbers just yet. When you get to the **results**, you can tell us **how much**: quantify here, and only here, and use the right numbers (as detailed under #7). By the time you arrive at the **conclusions**, the so what should be clear: what is your take-home message and why does it matter? Don’t reiterate what you’ve laid out before. If you did so effectively, readers should be able to arrive at the same conclusion on their own. As you construct your abstract, be aware of typing toward a rigid word count, typically 250.

At this stage of drafting a paper, you should also start identifying your **key words**: five terms that will help your article be discovered. These words can later morph into MeSH (Medical Subject Heading) terms, routinely used in bibliographic indexing. Finally: if you anticipate **tables** or **figures**, sketch them out now, leaving the actual values and statistics empty. By doing so, you will steer a clear course to your destination. For final measure, add a heading for **references** and start filing away those you may have on hand.

### 3. ‘Entitlement’: an often-overlooked core component

An abstract must include a well-appointed title, which in turn should serve as an effective “hook.” It should turn the casual peruser into an intrigued reader. A title should be descriptive and brief (no more than 15 words). Two short phrases separated by a colon often work well. Be imaginative, but only to a point. Don’t be cute or amusing, or do so in small measure only and with consideration of the specific context. Take for example the potential evolution of this article’s title:

- **Abstractification** is the neologism I first used as a subject line for an email message to trainees and colleagues, encouraging them to attend my informal presentation entitled:
- **“Abstract It: Otherwise No One Is Likely to Read (or Find) Your Work.”**
- By the time I sat down to write towards publication, I opted for something slightly playful (after all, I had the young readership of Connect in mind), followed by an objective description: “Abstract Art: Twelve Tips to Help You Write an Effective Abstract.”
- Were I next to prepare it for publication in a scholarly bibliometric outlet, I would settle for a staid title, such as the formal “Abstract Quality: Predictors of Preliminary Article Rejection in a Scholarly Journal.”

### 4. An abstract is not a summarized article

Distilling an abstract out of an article risks missing the forest of meaning for the detail of its trees, of paying untoward attention to non-critical details. An abstract is much more closely related to a poster than to an article: both distill the “elevator pitch” of what you are aiming to convey into precious few words. Aim to **build up** from an abstract, rather than to **distill down** from an article.

### 5. An article is an expanded abstract

The corollary of the previous point is than the scaffolding for an article can include not only the abstract (critically), but also bibliography, tables, and figures – even well before data are available and cells filled in. As you expand on the various sections, you can (and should!) revisit your abstract iteratively. The abstract is the underlying skeletal structure of an article. But bones are constantly remodeled organs, even if they appear to be permanent structures: ossified is a misguided term in this context.

Consider progressing in an orderly sequence (from title to bibliography) or hopscotch across sections, so long as you keep moving forward, while keeping the demarcations intact. As you write, become well acquainted with the instructions for authors and refer to examples of articles in the periodicals (or meetings) to which you intend to submit.

### 6. Follow basic epidemiology principles: PECOT

Scholarly abstracts of data-based reports should address all aspects of the mnemonic, particularly in the method and results sections. Apply the PECOT rubric as a thought experiment or quality-control measure of sorts. Let’s see how I fared in the example of my own abstract:

- **Population**: 1,680 original research articles (61% out of 2,764 submitted).
Exposure(s) (or Intervention[s]): Articles characterized by 1) poor content fit (32% of those submissions rejected unreviewed); 2) methodological limitations (33%); or 3) poor abstract quality (35%).

Control (or Comparison): Articles considered satisfactory on all three characteristics (1,084 articles, or 39% of those submitted).

Outcome: Unreviewed rejection (i.e., prior to undergoing peer review).

Time: The five-year period ending in December 2015.

7. Include the right numbers—in the right dose
Be quantitative and numerical in your results, not qualitative and descriptive. Not all numbers are created equal, and there is a hierarchy to numbers: “More” or “less” are vague adjectives; actual numbers are preferred; numbers with percentages even better. Point estimates and confidence intervals are generally better than simple indications of statistical significance, especially if lacking numbers ($p=.003$ is better than $p<.005$, and much better than a simple asterisk). Confidence intervals or measures such as number needed to treat encompass additional information in them and are clinically informative.

Don’t bog down your abstract or your reader with unnecessary numerical detail in an effort to be scientific or accurate; be selective and have a clear goal in mind. Round numbers to meaningful metrics – don’t aim to be over-precise and uber-scientific. Is a mean age of 16.32 years meaningful in any way?

8. Shed the fluff: every word counts and must do work
Spare your readers from telling them how important your study is. Let them decide for themselves. And while you are at it, shed all unnecessary, flowery, amazing, or irrelevant adjectives and adverbs. Shed them all. Good writing is akin to topiary gardening: clipping extraneous detail away to reveal underlying content.

9. Be understated: let the abstract speak for itself
This is no infomercial; provide just the facts. You can feel confident that your abstract works if your conclusion is no more than one or two sentences long and flows logically from the previous sections.

10. Don’t editorialize
No opining. No explaining. No apologizing for your study’s limitations. Zero room for your feelings here (sorry). The discussion section comes later, so save the back-and-forths of on-the-one-hand-on-the-other until then. Show, don’t tell.

11. Typos and the little things than can undo you
A typo is like a bad ingredient that spoils the broth on contact. **Omit thm a tall kosts.** They are distracting and show poor attention to detail. If you can’t get this much right, can your contents really be trustworthy? Format per the instructions for authors. Obsessively. If necessary, contact the editorial office for clarification. This is no place to draw outside the lines.

12. Whatever else you do, finish with your abstract
Start with it, polish it along the way, finish with it. This is not redundancy: it is a wise investment of your time and energies. It is the only piece of your work that will be seen at first, and it can doom you from the get-go. Don’t overlook it or come to it the day before the submission is due: abstract it!

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**About the Author**

**Andrés Martin, MD, MPH,** is the Riva Ariella Ritvo Professor at the Yale Child Study Center and editor-in-chief of the *Journal of the American Academy of Child and Adolescent Psychiatry.*

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AACAP’s Legislative Conference and Assembly Meeting

May 11-13, 2017

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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Treatment of Traumatic Brain Injury in Youth: The Integral Role of the Family

Desiree Shapiro, MD, Alyssa Murphy, MA, Michelle S. Horner, DO

During my first year of child fellowship, I cared for a 16-year-old girl who suffered a traumatic assault with subsequent brain injury. “Alicia” had sustained stab wounds to her neck, large vessel injury, and cerebrovascular accident, necessitating numerous procedures, including a craniectomy. My path and Alicia’s would cross again and again during my various clinical rotations. As I worked with her and my colleagues to help her regain her health, her story proved instructive, not only about the rocky path to recovery for those with traumatic brain injuries (TBIs), but also about how that path might have been smoothed, particularly with the help of her family.

Though Alicia was medically stabilized one month after her injury and later transferred to a rehabilitation service for additional recovery, a return to full health would be long and difficult, in part due to the nature of her injuries. TBI occurs when a brain injury results in the disturbance of normal brain functioning; the severity may range from mild to severe.1 In the United States, adolescents aged 15-19 have the second-highest rate of emergency room evaluations and hospitalizations for a TBI.2 From 2002-2006 data, there were 129,211 and 186,089 total TBI-related emergency department visits, hospitalizations, and deaths among 10-14-year-olds and 15-19-year-olds, respectively. There is likely an underrepresentation of the number of youth with actual injury, impairment, and limitations, as these numbers do not account for those individuals who saw outpatient physicians or who did not receive medical care.

Children and adolescents with TBI often face cognitive, behavioral, social, and physical impairments. Addressing each area of possible damage, often requires a multi-specialty team consisting of surgeons, psychiatrists, social workers, and more. Further, family involvement is imperative to ensure treatment compliance when the patient is discharged and continues recovery at home. In order to optimize functioning and rehabilitation, coordination between the medical services and family is essential.

The attack, which would have been devastating to someone with full mental health, was even more so for Alicia, who had struggled with substance abuse and family conflict, and had previously run away from home before the assault. And though she had a team of doctors on the inpatient hospital service including neurology, neurosurgery, rehabilitation medicine, and psychiatry specialists, it was difficult for her family to coordinate all of the care and rehabilitation follow-up. After her first discharge, her mother could not keep up with the many recommendations and appointments, and brought Alicia back to the hospital. During her complex recovery, she traveled between the medical floor, inpatient psychiatric unit, home, emergency room, and an emergency shelter. A primary factor in her inability to maintain placement was her family’s inability to play a central role in her care.

Clinical Considerations

Symptoms associated with TBI may be varied and fluctuating. Patients may have trouble with memory, language, problem solving, attention, and executive functioning abilities. They may later experience academic problems, personality changes, anxiety, depression, posttraumatic stress disorder, behavioral concerns, isolation, and difficulties in school, home, and in relationships. Adolescents and children with TBI may exhibit emotional lability, disinhibition, anger, aggression, anxiety, apathy, paranoia, or amotivation among other possible presenting concerns. Personality change due to TBI can take the form of severe affective dysregulation. In youth ages 5-14 with TBI who were followed at
baseline and at 6 months, attention, processing speed, verbal memory, IQ, and executive function were found to be significantly associated with personality change in a recent study done by Max et al.³ Personality changes may be linked to the severity of TBI injury as well as lesions in the dorsal prefrontal cortex, specifically the superior frontal gyrus.⁴

In Alicia’s case, the physical trauma immediately addressed in the ER foreshadowed deeper injuries yet to manifest. Prior to the attack, she had never seen a psychiatrist, nor had she ever been hospitalized, although she did have a history of substance use, family conflict, and running away from home. After her injury, she experienced problems with behavioral control, communication, problem solving, and emotional lability. Her mood instability and impulsivity mixed with her fragile medical condition and nonadherence put her at high risk for re-injury or self-harm. Providers and staff were alarmed, understanding that should she seriously hit herself in the head or fall when refusing to wear a helmet before her injury was healed and protected by the final neurosurgical intervention, a devastating outcome could result. She commented that she did not care about this possible outcome and was occasionally verbally and physically aggressive with staff and her family. She also expressed suicidal ideation, and was eventually transferred to the psychiatric unit. Plans for neurosurgery were postponed due to concerns about her mental health. The neurosurgery team was apprehensive about her ability to comply with post-operative care, especially given her comments about suicide and attempts to hit, and therefore reinjure, herself.

There is an association, but not any definite causation, between pre-injury psychiatric illness and development of TBI. Whelan-Goodinson et al.⁶ conducted a cross-sectional study looking at psychiatric disorder after TBI. Fifty-two percent of the sample received a psychiatric diagnosis preinjury, similar to data from Gould et al.,⁵ who found that more than half of the participants with TBI had a psychiatric disorder, most commonly substance use, mood, or anxiety disorders. Youth who suffer from TBI therefore have multiple physical and psychiatric vulnerabilities,⁷ and they have many needs, including various rehabilitation services such as cognitive, occupational, physical, and speech-language therapies. But there are often barriers to obtaining the level of services needed. Distance from treatment can be a significant hurdle: not all communities have easily accessible inpatient rehabilitative services or outpatient programs. And high costs of required care, far distances to appointments, a potential lack of understanding or support about a child’s condition or the system of care, and language barriers are other obstacles for families. Longer-term treatments after medical stabilization may be challenging to set up or continue because of specialist shortages. Cognitive services, including speech therapy, occupational therapy, and services provided by education specialists, neuropsychologists, and physicians are cited as the highest unmet and unrecognized need during the first year after traumatic brain injury.⁸ Slomine et al. emphasize the importance of primary care/pediatric monitoring to ensure that patient needs are being addressed and assessed over time to optimize health after injury.

After she became used to the structure of the psychiatric inpatient unit, Alicia was deemed stable for discharge; however, she did not remain in the care of her family for long. Her family attempted but later reported an inability to care for her at home due to her behavior and her drastic personality change with mood fluctuations, threatening comments, and emotional lability. The extent to which her changeable moods were related to TBI was something debated at length by her medical team. Some thought her history of running away and drug use was predictive of her current state; some suggested her TBI was aggravated by posttraumatic stress disorder; others attributed her moods and behavior to the TBI alone. Whatever the cause, her caretaker wondered when she would be “back to normal,” a benchmark she seemed to approach just enough to warrant transfer from the psychiatric unit to an emergency shelter, then backslide and necessitate a return to the unit.
Family Support in Recovery

Alicia’s family’s inability to care for her was a major stumbling block in her rehabilitation, resulting in a further source of instability as she struggled to recover. Beyond medical services, an outside support system, such as the patient’s family, is vital to recovery; they can supervise treatment adherence, coordinate follow-up appointments, and bolster flagging spirits so that rehabilitation continues once the patient is discharged. Family involvement in traumatic brain injury care has been shown to be a key factor in achieving quality care and improving functioning.9,10 But not every family is equipped to handle the demands of managing care for a TBI patient. Alicia’s family tried to make the transition from hospital to home as seamless as possible, but they found keeping up with the recommendations and appointments difficult, in addition to managing her unpredictable moods and behaviors.

In order for families to successfully transition their child/adolescent to outpatient treatment, they must be properly trained in treatment adherence. TBI in particular is a medical condition that requires substantial psychoeducation and parent coaching. Similar to educating parents and families about schizophrenia and bipolar illness, education about TBI helps improve treatment adherence and encourages empathy. It is not sufficient to discharge a youth with TBI home with medication instructions and follow-up appointment details; there should be a family assessment, comprehensive discussion of why a patient may be acting or responding in a certain way, practical advice on how to help, and referrals to supportive services such as counseling.

It is important to recognize family strengths and potential barriers, including family dysfunction, when planning follow-up care and management of medical concerns at home. According to a prospective study investigating family functioning after TBI in youth, some families seem to be at an increased risk for relational dysfunction after brain injury. Looking at standardized family functioning interviews and self-report assessments, researchers found that the most important influences on family functioning after pediatric TBI included preinjury family functioning, preinjury family life events or stressors, and postinjury development of psychiatric illness in the child or adolescent. They noted that identification and treatment of both family dysfunction and youth psychopathology may improve patient outcomes.11 In a 2002 longitudinal study with 53 children with severe TBI, 56 with moderate TBI, and 80 with orthopedic, non-brain injuries, Taylor et al. found that post injury progress was influenced by the family.12 For example, recovery of math skills was seen in those youth with low family stress, and academic decline was associated with disadvantaged backgrounds. In addition, social disadvantage was associated with and/or predicted worse behavioral outcomes and less progress in socialization skills. According to Potter et al.,13 higher levels of authoritarian parenting and fewer family resources were associated with greater executive difficulties, which included emotional and behavioral regulation, after TBI. These study results support the importance of the social and family impact in youth recovering from TBI.

In recent years, there has been a call for better definitions of optimal family environments in recovery from early childhood TBI to improve interventions.14 These findings that preinjury family functioning and postinjury behavior of children are linked indicate that there may be risk factors to consider in outcomes for TBI recovery.15 Supportive families may provide a hopeful attitude as well as assist with cognitive, social, and behavioral deficits. In a prospective cohort study examining family outcomes after pediatric TBI, families of 81 children aged 6-15 were followed for three years.16 Lower levels of rigidity and higher levels of expressiveness were found to be associated with positive outcomes, promoting a flexible approach with good communication in TBI recovery. According to this study, successful adaptation to life with TBI involved families who “were more capable before the injury, had more social support and problem-solving skills, used resources more effectively, had greater involvement in activities, were more cohesive, had better family relationships, better communication, were more expressive, and had a more positive belief system than those who had poorer outcomes.”16 In contrast, higher
levels of family distress, mental illness, inflexibility, and a less positive belief system were associated with the greatest challenges. Rivara et al. concluded that families at risk for poorer outcomes should be identified early and strengthened to encourage positive change.

Quality information and preparation may help families know what to expect and facilitate care for their loved ones. Empowering families is a great strategy to promote quality care. Interventions targeting family communication and caregiver psychological health may also help behavioral problems in adolescents with TBI. Some researchers are investigating online positive parenting skills programs for pediatric TBI recovery that may help increase access, education, and support as well as lead to long-term improvements in behavioral problems and functioning.

Numerous studies have shown that the influences of family and their interaction with the environment have an impact on outcomes of TBI, and some families are more equipped than others to manage appointments and high-intensity needs at home. But even in families with strong communication, caregivers may find themselves under substantial emotional stress; therefore, it is important for medical staff to be mindful of these effects on youth and the family system. The more stable the support network, the higher likelihood that the youth with TBI will get his/her needs met. A case manager or other team member may be able to assist in troubleshooting logistical details such as transportation, supplies needed, and respite care.

Alicia was eventually transferred out of state to continue her recovery because her family could not take her home, something that she came to recognize and understand. Without the support of her family, she found her own way to stabilize her situation: she prized the relationship security that she found in the hospital, preferring the same sitters and nurses to be with her during the day. And she became more able to express her feelings, such as her longing to return to her family. As her medical team began to learn how to manage her moods and behaviors—through understanding her concerns and insecurities, being mindful of countertransference—it became clear that communication, preparation, and psychoeducation were important for everyone involved in Alicia’s care: her medical team, her family, and Alicia herself.

Conclusion
Traumatic brain injury is a complex condition that may have psychosocial, cognitive, behavioral, motor, and physical effects. Clinicians, caregivers, and the community ideally should be involved in supporting youth who suffer from TBI. Currently, primary services for youth with TBI include psychotherapeutic and psychopharmacologic approaches to target symptoms that are the most troubling and impairing to the child or adolescent. There is a definite need for more research on treatments for pediatric patients with TBI. One crucial aspect in the rehabilitation of youth with TBI is family-centered care. Supporting and educating family members and encouraging service integration not only relieve stress and anxiety in caregivers, but also help to promote wellness and healthy development of the youth with TBI. More research is needed to identify specifics about the environments and support systems that might promote recovery.

Take Home Summary
Youth who experience traumatic brain injury (TBI) have unique medical and emotional needs. Family support is essential in the recovery process of these youth. Discussion, preparation, and planning for aftercare should begin early with the assistance of the medical team. Barriers to providing quality care should be addressed to allow for troubleshooting of these difficulties. Clinicians should involve the family in the healing process as much as possible to ease the transition home and to promote adherence.

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A Literary Perspective on Foster Care in the United States

Celina R. Jacobi, MD, Anne L. Glowinski, MD

One thing I appreciate about psychiatry is the field’s consideration of a patient as a person with a life outside of the doctor’s office. Yet, as medical school drew to an end, I knew little about one particular patient population I anticipated serving as a future child psychiatrist: children in foster care. According to the US Children’s Bureau, the number of children in foster care served nationally decreased almost 19% (from 797,000 to 646,000 children) between 2005 and 2012, but now is on the rise again with 653,000 served in 2014.\(^1\) Approximately 50% of children who enter the foster care system are returned to their parents, but 20-30% of those children will reenter the system within one year.\(^1\) In most states, children age out of the system at age 18 with no support and no one to turn to in a crisis; between 11% and 36% of those who age out become homeless, and only 40% find employment.\(^2\) A recent study in *Pediatrics* showed that former foster children are 2.3 times more likely to report poor general health than economically secure young adults.\(^3\) This is congruent with chronic stress research, which shows that exposure to chronic stressors can lead to adverse health outcomes. Studies show that 80% of children in foster care have significant emotional and behavioral problems.\(^4\) Tragically, behavioral health service use drops by 60% within a month of discharge from foster care, and 90% of young adults with externalizing disorders who were formerly in foster care are arrested within 1 year of aging out.\(^2\) What is the US foster care system that produces these sobering outcomes? To begin to answer this question, I started from a historical perspective to learn how the system developed and how it currently functions.

I previously assumed that the foster care system had been carefully designed to support a child’s wellbeing and development; however, I learned that programs have been stacked on top of each other with apparently little evidence of practice success or re-evaluation. Foundling (or orphan) homes were first established in Italy in the 14th century, replacing informal kin care, and only became common in North America in the 1800s.\(^5\) At that time, religious organizations opened orphanages, the predominant focus of which was the provision of shelter and food to meet the children’s physical needs with less emphasis on the provision of nurturance or interpersonal interaction to meet their psycho-emotional needs. When the first White House Conference on Children was held in 1909, child welfare professionals concluded the following: 1) whenever possible, children should be raised by their own families; 2) when removal of children from their families was absolutely necessary, they should be raised in a family setting; and 3) no child should be removed from parental care due to poverty alone.\(^6\) However, those noble mandates were not implemented broadly until the 1970s, coinciding with the decreased prevalence of orphanages and an increase in the availability of foster care. Additionally, the second half of the 20th century saw a shift in the population entering foster care, transitioning from children of ill or poverty-stricken parents to those who were neglected or abused.\(^6\)

The US federal government funds and has regulatory oversight of the country’s foster care system, while state agencies determine the actual structure of the provided services and oversee their implementation. At the community level, private agencies or public child welfare programs are responsible for the recruitment and certification of foster parents, the safety and placement of children, and the rehabilitation of the children’s birth parents. Though I was not surprised to learn of accounts of understaffed agencies, I was nevertheless shocked that most child welfare caseworkers are responsible for an average of 14.6 new investigations per month, which is above the Child Welfare League of America’s recommendation of 12 active (i.e., ongoing) cases per month.\(^7\) Even with the help of guardians ad litem (GALs), who are either community volunteers...
or lawyers appointed by the courts to investigate the best interests of a child, such a system cannot but fail to meet the needs of so many children. Also, with the national shortage of foster homes, up to 6 children can be placed in a single home, potentially challenging a foster parent’s ability to adequately nurture each child. Federal law requires review of each child’s case every 6 months with ongoing efforts to find the child a permanent home. However, it may take years for a child to find a stable placement, and many never do. The system’s priority remains reunification of a child with his or her biological parents, who are given time to take parenting classes, find employment, and maintain a safe household before their parental rights are terminated. While I initially thought favorably of this goal, reading accounts describing toddlers and infants waiting for years as their parents struggle to demonstrate that they are ready to have the children return to their care—all the while becoming increasingly attached to their foster parents—has made me question the appropriateness of prolonged attempts at reunification between children and their biological parents.

After better understanding the history of our precarious foster care system, I wanted to learn about children’s experiences in the system. I started off with Another Place at the Table by Kathy Harrison, an experienced foster parent and the adoptive mother of two former foster children. Her vignettes about the children who passed through her home gave me insight into the children’s emotional experiences of being torn away from their families (even if neglectful or abusive), separated from their siblings, and placed with strangers. I empathized with the children’s disappointment when their biological parent does not show up, the anxiety provoked by chronic promise-breaking, and the anger over experiencing abandonment. I understood the children’s likely need to act out or break rules to see if foster parents would reject and abandon them like everyone else seemingly had. Through Harrison’s book, I learned how the foster care system inadvertently reinforces those emotional and behavioral disturbances that children initially develop due to abuse or neglect. In contrast, Gay Courter’s I Speak for This Child: True Stories of a Child Advocate chronicles the full longitudinal course of children in the system from entrance to exit. As a guardian ad litem, she interacts routinely with children’s biological parents and describes the frequent challenges of family reunifications. I was most struck by Courter’s conclusion that it sometimes is better to leave a child with his or her biological parents if the abuse towards or neglect of the child is not life-threatening and if, at its core, the parent–child relationship seems to be positive and one of love. After witnessing children change for the worse with repeated moves and placements, Courter takes the position that we are choosing between two evils. I initially was horrified by the idea of leaving children with their abusers, but, given her witnessed experiences, can understand her perspective: she describes that, ten years down the road, many of the kids with whom she worked had never found a stable home, many were institutionalized, and many had had their own children who subsequently had been removed from their care due to abuse or neglect. Courter anticipated my doubts about the utility of her efforts when she wrote that even though it does not always feel like she is able to make a readily recognizable difference, she knows that, in attempting to help each child with whom she works, she does—even if just for moments, minutes, or hours.

Lastly, I read Three Little Words: A Memoir by Ashley Rhodes-Courter, the adopted daughter of Gay Courter. In this autobiography, Rhodes-Courter writes about her experiences as a foster child and about her eventual adoption. After she was removed at age three from her mother’s care due to neglect, Rhodes-Courter spent nine years moving between fourteen different foster homes. She was separated from her brother, who developed behavior problems, and was eventually adopted without him. In several ways, her story was similar to others I had read. However, an aspect of Rhodes-Courter’s story that differed from others’ involved her experiences living in a group home prior to her adoption. She describes the experience of growing up in what effectively resembled a dorm with rotating
supervision. Although she developed a few close relationships, she repeatedly was left devastated when the caregivers to whom she had grown close found new jobs and left her. I originally had considered group homes to be a potential ready solution for more independent, older kids but now realize that I had underestimated the continued need for safe, stable, and constant relationships that teenagers have. Rhodes-Courter writes that, when she was adopted by Courter, she simultaneously was wracked by guilt (feeling that she perhaps was giving up on her biological family) and constantly worried that her new adoptive family might decide they no longer wanted her and “give her back.” She describes that it took years for her to trust them, to expect stability, and to finally say, “I love you.” Rhodes-Courter’s story is a testament both to the potential negative sequelae of years spent in the foster care system and to the resiliency that some children demonstrate despite significant early life adversity.

While I can never fully appreciate what children in foster care experience first-hand, through my exploration into the history of the foster care system and my sampling of several narratives of both the workers and children who have been a part of the system, I have imagined their situations and shed tears. My readings still weigh heavily on my mind. With the goal of protecting the well-being of children, we remove kids from homes deemed to be unsafe and place them in a system with inherent limitations that cannot always ensure that the diffuse needs of these children will be adequately met. Though learning about the foster care system and some of the children who have been in the system has raised many concerns for me, I now better understand some of the complexities of this system and realize that there is no ready solution. Fully restructuring the US foster care system would be a monumental task.

In the course of my reading, I did think of two ideas that I believe could improve the outcomes of foster care graduates. One would involve the establishment and maintenance of a much stricter time limit of 2 years for attempts at parental reunification. While the Adoption and Safe Families Act of 1997 requires a state to file to terminate the parental rights of children who have been in foster care for 15 of the preceding 22 months, there are a number of exemptions to this Act, some of which are more beneficial to the child than others. For instance, the exemption clause for children whose best interests are not served by adoption is eminently reasonable, as long as the “best interests” assessment is made in developmentally informed and sensitive ways. Other clauses are meant to protect the rights of parents but end up perpetuating delays in permanent placement. The second idea involves a continuance of benefits, particularly health insurance and job training, until the age of 26 for those who age out of the system—an additional expense that, I anticipate, would ultimately reduce longer-term costs currently associated with the poorer outcomes of those previously in the foster care system.

While I recognize that my current ability to influence the foster care system is limited, after completing my training, I aim to help the foster care population (both those in the system and those who have aged out) by making time to treat and advocate for foster children—knowing that, in the spirit of Gay Courter’s work, I can make a difference in each child’s life even if only for a moment, a minute, or an hour.

**Take Home Summary**

Through an exploration into the history of the foster care system and a sampling of several narratives of both workers and children who have been a part of the system, the author and her mentor outline a complex system with inherent limitations that currently cannot always meet the diffuse needs of the children in foster care. Though there does not appear to be a ready solution, the author and her mentor outline two ideas that could improve the outcomes of foster care graduates. They also underscore that, despite the complexities and inherent limitations of the system, the individual provider can make a difference in a foster child’s life, even if only for a moment, a minute, or an hour.
References


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Disclosure: Drs. Jacobi and Glowinski report no biomedical financial interests or potential conflicts of interest.
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