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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.

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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.
With its 2010 Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC), the American Heart Association removed its direction that first responders “look, listen, and feel for breathing.” Many of us in the healthcare field internalized these words during Basic Life Support (BLS) re-certification trainings. Yet, despite its persistent absence from the current official guidelines, I continue to consider this pithy phrase a tenant of assessment. It directs us to be deliberate and attend to our multiple senses to increase our openness to and awareness of stimuli (internal and external)—all with the goal of facilitating and improving assessment. In this manner, the phrase is indeed “basic” (i.e., fundamental) and possesses vast utility and generalizability. Already recognized by some is the extension of this adage to the practice of reflection, and it is with this in mind that I invoke “look, listen, and feel” in reference to the diverse articles in this issue of Connect.

In “Psychiatrists Should Be Mental HEALTH Professionals” (p. 6), the second installment of his “Lab to Smartphone” column, Rettew encourages us to reflect upon our identities as child and adolescent psychiatrists. He advocates that we not just limit our professional scope to understanding psychiatric pathology and restoring mental health, but that we also deliberately and proactively attend to an understanding of mental health and wellbeing and how best to preserve them—both for our patients and ourselves, as healthcare providers. Our society’s expanding interest in wellness is perhaps underscored by the recent announcement that, this past January, almost a quarter of the entire undergraduate student body at Yale (almost 1,200 undergraduate students) enrolled in a single course titled, “Psychology and the Good Life.” As described by The New York Times, this course “tries to teach students how to lead a happier, more satisfying life in twice-weekly lectures.”

With the opioid epidemic crippling our country, opioid use disorders and, more broadly, substance use disorders, have exploded into our field’s consciousness. The review of medication-assisted treatment of substance use disorders among adolescents by Resczenski and Whitmore (p. 10) presents multiple ways by which we can move from awareness and recognition of the problem to the provision of pharmacological intervention—preferably in combination with psychosocial interventions to optimize comprehensive treatment.

The remaining three articles in this issue of Connect address topics that are likely less in the forefront of mental health providers’ minds and, as such, warrant additional looking, listening, and feeling—particularly through introspection and a challenging of potential assumptions. Cunningham and Brewerton (p. 15) ask us to recognize “too much of a good thing” in the form of pathological exercise (PE)—an entity that can present as a symptom of an eating disorder or body dysmorphic disorder but, importantly, also can exist as an independent primary condition in which an individual’s relationship with exercise negatively impacts that individual’s physical and mental wellbeing. They point out that, given the frequency with which children and adolescents engage in sports, it is important that clinicians working with youth consider and recognize PE in this population. Raj (p. 21) reviews the topic of domestic minor sex trafficking. In his article, he shares that the vast majority of survivors of domestic sex trafficking report having had some form of contact with a healthcare provider in the preceding year while being trafficked, and he reviews some of the challenges that healthcare providers face in identifying these exploited youth. He emphasizes the mental health needs that this population frequently has both prior to and as a result of sex trafficking. Finally, Pawlowski discusses bullying in the workplace—more specifically, bullying in medicine, and, most specifically, bullying in psychiatric residency training. She encour-
ages us to acknowledge the data that show that our field of psychiatry is not immune to bullying behavior, and to consider our roles in both recognizing bullying and helping shift our culture in psychiatric medicine to better ensure that bullying does not occur among colleagues, including with or among our trainees.

Having entered my final calendar year as editor of JAACAP Connect, I am pausing more often to look, listen, and feel. I am grateful for the opportunities that my Connect role affords—namely, the chance to work with authors to bring their ideas and experience to publication and, in so doing, the chance to increase action and awareness around various clinical and professional issues affecting our field.

Oliver M. Stroeh, MD
Editor

References


AACAP AWARDEE SPOTLIGHT:
Suzan Song, MD, MPH, PhD

2009 AACAP EDUCATIONAL OUTREACH PROGRAM FOR CAP RESIDENTS Awardee

Attending my first AACAP Annual Meeting in Hawaii is likely the reason why I continue to be an active member. I remember being intimidated and confused about what sessions to attend, and how to best use the conference time. I found the mentorship and guidance through the EOP supportive and generous, making me want to be more involved not only in the organization, but also in child psychiatry. This is where I learned of the impact of mentorship, and it has directly influenced my current position, where I provide career mentorship for medical students and residents with an interest in child psychiatry.

2011 AACAP PILOT RESEARCH Awardee

Project Title: “The Importance of Family: Intergenerational Stress in Burundian Former Child Soldiers”

I examined how the experience of being a child soldier (at the individual and societal levels) affect parenting practices and their children’s mental health. Understanding the influences of perpetrating violence on the relationship with one’s child and family, can lead to early prevention/intervention programs for children of child soldiers who may have mental health needs.

Funding for this feasibility study was the start of my research career. Prior to this, I was focused on clinical work, and had never really conducted a study independently. This study fostered my interest in pursuing research more seriously, to the point of completing a post-doctoral research fellowship and PhD on the topic. This single award allowed me to take a simple question and turn it into a career, that also ultimately led to my position as a humanitarian protection advisor for the United Nations.

ABOUT DR. SONG

JOINED AACAP: DECEMBER 2009
WORKS AT: GEORGE WASHINGTON UNIVERSITY
POSITION: DIRECTOR, DIVISION OF CHILD, ADOLESCENT, AND FAMILY PSYCHIATRY; ASSOCIATE PROFESSOR;
SPECIALTY AREAS: COMMUNITY MENTAL HEALTH, CULTURAL PSYCHIATRY, GLOBAL MENTAL HEALTH

AACAP AFFILIATIONS

COMMITTEE WORK
Child Abuse and Neglect Committee
International Relations Committee

The Child Abuse and Neglect Committee was the first committee I had participated in. I was impressed and inspired by the dedication of CAPs to the well-being of children, through an interweaving of clinical experience, research, and policy. I currently am a member of the International Relations Committee, where I organize panels that educate about the issues of children and families in migration, as well as solicit articles for AACAP News that highlight issues involving CAPs from around the world.

REGIONAL WORK
Greater Washington Society
Northern California Regional Organization

I am thankful to have joined the Northern CA Regional Organization, first as Vice President, then as President. It was quite a learning curve, of how to prioritize local issues and keep the interest of CAPs in the region, while also working with the larger AACAP community. As Vice President, I organized our annual conference on global mental health - bringing global work to local issues. I have recently moved to the Washington, DC area and look forward to learning from and engaging with new colleagues.

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Psychiatrists Should Be Mental HEALTH Professionals

David C. Rettew, MD

At a recent get together, I was asked by someone I had just met what I do for a living. His response, after I told him I was a child psychiatrist, was, “So you drug up kids.” I get this a fair amount. This is our new identity in the public eye. The caricature of the psychiatrist has changed over the past few decades from the bearded therapist in a tweed jacket asking about a person’s dreams to a more antiseptic-looking doc in a white lab coat doling out “mind altering” medications.

Such a stereotype of psychiatrists isn’t fair or accurate, but unfortunately it contains at least a nugget of truth. We psychiatrists often like to describe ourselves as “mental health professionals,” a term also used to describe folks like clinical psychologists and others with slightly different backgrounds and training. It’s a term that seems hardly controversial in our community—but is it accurate?

According to AACAP’s online resources for medical students, a child psychiatrist is “a physician who specializes in the diagnosis and the treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents, and their families.” Disorders. This statement certainly seems to reflect what most child psychiatrists do in practice and how we are trained, but the question for this installment of Lab to Smartphone is whether we need to challenge this conventional definition as being much too narrow. Ask most child psychiatrists what they hope for with their patients, and you are unlikely to hear very many being content that their patients have “an absence of symptoms” or are “less miserable.” We want our patients not just to survive, but to thrive and to be able to lead lives full of happiness, accomplishment, and purpose.

To that end, we may be long overdue in taking a step back and looking at where we are positioned, how we are trained, and what tools we have at our disposal. For most of us, we are invited into our patients’ lives only after things have unraveled to a major degree. Then we use our training toward the goal of getting our patients back to “baseline,” armed with two main tools: psychotherapy and medications. Far too often, we fall short, and this unfortunate reality may not be that surprising given the way psychiatrists are educated. You can be a world expert in depression without knowing much of anything about happiness. You can be a thought leader in early trauma without needing to think much about the positive aspects of parenting that promote healthy brain development.

We find ourselves as psychiatrists in a bit of an identity crisis these days. Who are we? What, actually, do we do? Psychiatry’s origin was in the domain of therapy, but market forces have made that a difficult enterprise, especially for clinicians wanting to remain available for people who are not wealthy. We morphed into psychopharmacologists as new medications in the 1980s and 1990s emerged that seemed to offer great promise with less risk. Unfortunately, we are beginning to learn that perhaps the benefits of many of those medications were overstated with the risks being underappreciated. More recently, we have turned to neuroscience and, in the process, learned a ton. But despite all the stunning imagery of the brain and elaborate diagrams of our genome, it has remained difficult to operationalize that knowledge into day to day practice. The final sentence of seemingly every clinically oriented neuroscience paper ends with the same line—something akin to “these findings will hopefully improve early identification and treatment for individuals suffering from [insert disorder here].”

All this sounds a little bleak, but there is also great optimism. Knowledge about emotional–behavioral wellness and the paths to achieve it have grown dramat-
ically in the past two decades, and we have learned that things like mindfulness, physical activity, musical training, and positive parenting not only help keep healthy children well but also can be powerful interventions for those who are struggling or at risk. The scientific evidence and neuroscience supporting many domains of wellness and health promotion now well exceeds that of some of our more traditional psychiatric treatments (both in terms of certain medications and some forms of psychotherapy) that are much more commonplace in our field. Overall, these wellness elements can no longer be considered “alternative” or “fringe” or any other term we might use to justify our lack of knowledge or experience.

Luckily, people are helping us forge a new direction. At my own medical center in Vermont, child psychiatrist Jim Hudziak has created the Vermont Family Based Approach model, which is designed to fully incorporate family wellness and health promotion into day-to-day child psychiatry practice. No longer is it acceptable to have a treatment plan for attention-deficit/hyperactivity disorder (ADHD) that includes only methylphenidate. Instead, clinicians and trainees are taught to engage families around things like exercise, screen-time reduction, healthy eating and sleep routines, treatment of parental ADHD and other disorders, and mindfulness techniques. Interestingly, when we explain our treatment model to non-psychiatrists, the most typical response is a combination of both enthusiasm and bewilderment that such an approach has taken so long to find its way into mainstream practice.

Elsewhere, former American Psychiatric Association President Dilip Jeste made the focus of his recent tenure the advancement of “positive psychiatry” to complement similar advances in psychology. In the area of training, the recent child psychiatry milestones, which are standardized expectations for all child psychiatry fellows, now include the provision that our trainees have knowledge not only about illness but about wellness. This emphasis extends directly to our trainees as well in new initiatives designed to keep physicians healthy and resilient. In research, new models like the National Institute of Mental Health’s Research Domain Criteria (RDoC) push us to acknowledge the reality that we are working with full dimensions here rather than discrete categories.

New models of health care delivery also offer the hope that true mental health approaches like those described here will not only be beneficial for patients but financially incentivized, as well. As reimbursement plans slowly move away from fee-for-service models that reward expensive interventions for people who are sick to capitated systems that promote prevention and early intervention, there is the opportunity to enact some major adjustments to mental health care practice in alignment with these principles.

While psychiatrists will never desert those who are suffering most, the time is right for our field to reclaim ground that we never should have abandoned in the first place. The science is reminding us that mental health encompasses a full spectrum, and that for too long we have been ignoring half of it. What’s more, this science is ready to be utilized for the benefit of our patients and families not in a decade, but tomorrow, by making some modifications to what we choose to assess in our evaluations and monitor in our treatment plans. To be sure, there remains much that will need to be researched, measured, and fine-tuned, but make no mistake about it: this train is moving, and it is time to hop on.

References
About the Author

David C. Rettew, MD, is the program director of the child and adolescent psychiatrist fellowship program at the University of Vermont Medical Center and an associate professor of psychiatry and pediatrics at the University of Vermont Larner College of Medicine. He is the author of the book *Child Psychiatry: New Thinking About the Boundary Between Traits and Illness* and the “ABCs of Child Psychiatry” blog on the Psychology Today website. He is on Twitter as @PediPsych.

Disclosure: Dr. Rettew has received royalties for his blog for Psychology Today.

To Participate in the Lab to Smartphone Column

To suggest a topic for this column or to inquire about co-writing a Lab to Smartphone column with Dr. Rettew or another child psychiatry mentor, please send an email to david.rettew@med.uvm.edu.
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Medication-Assisted Treatment of Substance Use Disorders Among Adolescents

James Resczenski, MD, Charles Whitmore, MD, MPH

Substance use disorders (SUDs) are common among adolescents in the United States. Among community-based samples, as many as 1 in 4 adolescents meets criteria for abuse of at least one substance, and 1 in 5 meets criteria for substance use dependence. Early age of first substance use conveys risk of developing SUDs and faster transition time from first use to the development of SUD. Despite the frequency and severity of SUDs among adolescents, only 10% of adolescents with SUDs access mental health care for treatment. Although there is a paucity of Food and Drug Administration (FDA)-approved medications to treat SUDs among adolescents, medication-assisted treatment (MAT) strategies are well-established as effective for treating certain SUDs in adults.

MAT is a pharmacologic intervention for SUDs that is combined with evidence-based psychosocial approaches and is intended to be part of a comprehensive treatment plan often including psychotherapy, family interventions, and medical management. Therefore, MAT is often limited to specialized addiction clinical programs that can offer the interdisciplinary teams required to implement these comprehensive plans. MAT improves the benefits of behavioral therapy alone for SUDs and improves psychotherapy attendance rates. Proper implementation of MAT can increase abstinence rates among adolescents with opioid, alcohol, cannabis, and tobacco use disorders. As such, understanding available MAT options is important for providers who work with adolescents. With a goal of updating pediatric mental health practitioners, this article briefly reviews medications used for MAT in adolescents with SUDs, focusing on opioid, alcohol, cannabis, and tobacco use disorders. However, it is important to note that nearly all of the following medications are not FDA-approved for used in adolescents, and that more research is needed to determine their efficacy in adolescents with SUDs.

Alcohol Use Disorder (AUD)

Alcohol is the most commonly abused substance among adolescents: roughly 3.5% of adolescents meet DSM-IV criteria for alcohol dependence. However, there are no FDA-approved medications to treat AUD in adolescent patients. Naltrexone (Vivitrol; Revia), acamprosate (Campral), and disulfiram (Antabuse) are approved for treatment of adults with AUD. All of these treatments have large randomized control trials (RCTs) supporting use in young adults. Fewer studies in adolescent populations are available, though some do exist. Therefore, MAT in adolescents with SUDs involves using off-label medications that have been shown to be effective primarily in adults.

Naltrexone is an opiate antagonist that reduces the euphoria associated with disordered alcohol use. Acamprosate is thought to decrease craving through its antagonism of N-methyl-D-aspartate (NMDA) glutamate receptors. This antagonism equilibrates the excitatory–inhibitory balance disrupted by the increase of glutamate receptor sensitivity occurring in the wake of chronic alcohol consumption. Disulfiram creates an aversion toward alcohol via fostering an “acetaldehyde reaction” when alcohol is consumed: the drug inhibits the conversion of acetaldehyde, a usual byproduct of alcohol, to excretable acetate, so that imbibing alcohol leads to a buildup of acetaldehyde. Acetaldehyde, in turn, causes diffuse vasodilation leading to flushing, hypotension, reflex tachycardia, headache, nausea, and vomiting.

Opiate Use Disorder (OUD)

The emerging epidemic of adolescent opiate use disorder in the United States has sparked growing concern.
For adults with OUD, the FDA has approved the use of naltrexone, buprenorphine (Buprenex; Butrans; Subutex), and buprenorphine/naloxone dual-therapy (Bunavail; Suboxone). Of these medications, buprenorphine has FDA approval for patients aged 16-18. Given their benefits in adult opiate use management versus the risks of the OUD, these treatment options should be considered for certain adolescent OUD populations.

As described above, naltrexone is an opioid antagonist that reduces the euphoria associated with opiate use. Buprenorphine is a partial opioid agonist that can be prescribed alone or in combination with naloxone for the treatment of OUD. When comparing buprenorphine-naloxone as a detoxification agent versus as a maintenance agent in adolescents, maintenance therapy (over 12 weeks) has shown improved abstinence rates, decreased reported injections, and increased therapy session attendance among patients.\(^5\) Prior to prescribing buprenorphine-naloxone as a detoxification agent versus as a maintenance agent in adolescents, maintenance therapy (over 12 weeks) has shown improved abstinence rates, decreased reported injections, and increased therapy session attendance among patients.\(^5\) One reason for this additional requirement is the complicated process surrounding induction of buprenorphine. Methadone (Dolophine; Methadose) is a full opioid agonist used to treat opiate use disorders in adults; research exploring the efficacy of methadone treatment for adolescents with opiate use disorder is notably lacking.

**Cannabis Use Disorder (CUD)**

According to the 2015 National Survey on Drug Use and Health, 15.7% of 12- to 17-year-old adolescents had tried cannabis in their lifetime.\(^18\) Based on observational data, in a prospective study, Meir et al. showed chronic cannabis use to be associated with a decrease in IQ from childhood to adulthood; however, after adjusting for age at first use, this association only remained in patients who began regular cannabis use before the age of 18.\(^19\)

The current recommendation for adolescents with CUD is to refer patients to behavioral or family-oriented therapy, deciding which modality to use on a case-by-case basis.\(^20\) However, Brown et al. showed that after 6 weeks of behavioral therapy, 94% of patients who responded to therapy achieved at least 1 week of abstinence, suggesting that patients who do not achieve a week of abstinence by 6 weeks into therapy would merit either switching therapy modalities or augmenting therapy with MAT.\(^21\)

Currently no FDA-approved MAT is available for CUD in adults or in adolescents. However, a double-blind RCT of adolescents aged 15-21 (\(n = 116\)) showed an increased percentage of negative urine drug screens over an 8-week period in patients receiving N-acetylcysteine (Acetadote) compared to those in the placebo group.\(^22\) These findings were not correlated with differences in reported cravings, suggesting the possibility of an alternative mechanism.\(^23\)

**Tobacco Use Disorder**

In 2015, 17.3% of 12- to 17-year-olds reported having used tobacco in their lifetime.\(^18\) Three FDA-approved MAT approaches are available for tobacco use disorder—bupropion (Wellbutrin), varenicline (Chantix), and nicotine replacement therapy (NRT), but none of these approaches are currently FDA-approved for use in adolescents (although available data show promising results).\(^10\)-\(^12\)

In a double-blind RCT (\(n = 134\)), Gray et al. showed improved abstinence rates for smoking among adolescents receiving bupropion sustained release (SR) and psychotherapy compared to those receiving psychotherapy alone (27% versus 10%).\(^10\) In a small follow-up double-blind RCT, Gray et al. showed no statistically significant difference in abstinence rates between individuals receiving varenicline versus those receiving bupropion.\(^11\) Despite black-box warnings on both medications for risk of psychiatric adverse effects including suicidality, both aforementioned studies commented on the lack of any depressive or suicidal symptoms in patients receiving bupropion or varenicline.\(^10\),\(^11\) The results for nicotine replacement therapy (NRT) have been mixed. A double-blind RCT reported by Moolchan et al. showed statistically significant differences in abstinence rates between adolescent smokers receiving patch NRT versus those receiving placebo.\(^12\) However, a meta-analysis of the six published RCTs on NRT in adolescents failed to show significant improvement in abstinence rates among those receiving medical treatment.\(^24\)
Conclusion

When approaching adolescents with SUDs, specific patient-based treatment options must be individually considered. When reviewing the available evidence, it is important to note differences in study parameters including age ranges, symptom severity, patient motivation for success, comorbidities, required support systems, end-goal measurements, and dosages investigated. Notably, most studies included concurrent psychosocial therapy sessions, integral to MAT. These pharmaceutical treatments are not intended to function as monotherapies but rather as components of a comprehensive approach. Therefore, when providers describe MAT to parents and adolescents, in addition to discussing medication efficacy and possible adverse side effects, they must underscore the importance of comprehensive program adherence.

In the setting of co-occurring SUDs and non-substance mental health diagnoses, the Substance Abuse and Mental Health Services Administration highly recommends referral to dual-diagnosis programs that integrate care of both disorders into the same setting. These evidence-based programs focus on incorporating cross-trained practitioners, stage-wise treatments, motivational interventions, cognitive–behavioral approaches, and integrated medication services into the patient’s treatment plan.

Given the substantial limitations of existing data for any of the medications mentioned in this article for the treatment of adolescent SUDs, more definitive recommendations for adolescent populations will have to await further double-blind, placebo-controlled randomized controlled studies as well as observational studies with adequate adolescent sample sizes that stratify for varying support systems, severity of disease, motivation, concurrent mental health co-morbidities, and general demographics. Additionally, given the increased prevalence of concurrent opiate and alcohol abuse, specific studies oriented towards treatment of concurrent abuse disorders would be of great benefit.

Take Home Summary

SUDs are common among child and adolescent patients. Although a variety of medications are used to treat alcohol, opioid, cannabis, and tobacco use disorders in adults, due to the lack of available randomized controlled trials for younger children, these pharmacologic interventions are considered off-label when used to treat child and adolescent patients. For providers who lack addiction experience, managing adolescents with substance use disorders should entail presenting patients and families with treatment plans that involve medication-assisted treatment (MAT), including referral to clinical programs with the interdisciplinary teams capable of providing comprehensive care as part of the MAT strategy.

References


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**About the Authors**

**Jim Resczenski, MD**, is a first-year resident in psychiatry at the University of Colorado School of Medicine, Aurora, CO. He is interested in child and adolescent psychiatry.

**Charles Whitmore, MD, MPH**, is a third-year resident in psychiatry at the University of Colorado School of Medicine, Aurora, CO. He is part of the program’s integrated research track and is interested in LGBTQ+ health, substance use disorders, and child and adolescent psychiatry.

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

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Too Much of a Good Thing: Could Your Patient Have Pathological Exercise?

Hayley Elisabeth Cunningham, BS, Timothy D. Brewerton, MD, DFAACAP

Many leading causes of disease and mortality in the United States are intimately tied to an unhealthy diet and sedentary lifestyle, and this is news to no one.¹ For many, life-long eating patterns and the perceived importance of exercise stem from childhood and adolescence. The habits, or lack thereof, displayed by immediate family and peer influences play an essential role in setting the lifestyle course for many youth, for better or worse. Despite the increasingly limiting time constraints that pediatric and adolescent primary care providers and psychiatrists face, it is essential to address unhealthy dietary habits and encourage regular physical activity to adequately promote child and adolescent health.

What may come as news to some, however, is that psychiatrists and primary care physicians have a shared responsibility to encourage some young patients to reduce the quantity and intensity of their exercise. For a small but significant cohort, exercise is already an integral part of life and sense of self. While many well-adapted young people define themselves through athletic involvement and benefit from structure, discipline, and comradery as a member of a team or working toward an individual fitness goal, some push themselves too far. For many, exercise serves as a coping mechanism that may be initially adaptive. However, they can ultimately feel the need to exercise with increasing frequency, intensity, and duration, perhaps to the point of injury. When injured, they push forward with their regimen or become wracked with frustration and anxiety. If life gets between them and a scheduled workout, they can experience emotional, even physical, withdrawal symptoms. Individuals relying on physical activity as a primary coping mechanism face the additional weight of emotional issues that led them to exercise, leaving them in even greater emotional turmoil and without adequate coping skills to adapt. Exercise comes to be the most important aspect of life, taking precedence over other responsibilities and wreaking havoc on their physical and mental wellbeing. For these patients, typical messages of encouragement to lead a healthy lifestyle are actually harmful.

What is being described here is pathological exercise (PE). PE is currently not a diagnosable mental illness found in the DSM-5,² but it can be a symptom of an eating disorder (ED). PE has been described as either primary or secondary,³ as well as either an addiction or a compulsion. Primary PE exists without an accompanying ED or body dysmorphic disorder (BDD); thus the primary motivations to exercise are the rewards of exercise itself, including stress relief, improved self-image, and alterations in neurotransmitter release responsible for “runners’ high.” Secondary PE exists as a symptom of another disorder, usually an ED; the desire to exercise is secondary to the desire to lose weight or attain a leaner or more svelte physique. It is widely recognized that some with an ED adopt exercise as a maladaptive compensatory behavior to burn calories, but fewer realize that exercise can be problematic in the absence of an ED. Even if physicians can conceive of exercise in itself as potentially maladaptive, it can

“Young patients will not present you with this information without pointed questioning or collateral input. It is imperative to ask specifically about their relationship with exercise. How important is exercise? Why do they exercise? How do they exercise? What happens if they are unable to exercise?”

¹Young patients will not present you with this information without pointed questioning or collateral input. It is imperative to ask specifically about their relationship with exercise. How important is exercise? Why do they exercise? How do they exercise? What happens if they are unable to exercise?“

²What may come as news to some, however, is that psychiatrists and primary care physicians have a shared responsibility to encourage some young patients to reduce the quantity and intensity of their exercise. For a small but significant cohort, exercise is already an integral part of life and sense of self. While many well-adapted young people define themselves through athletic involvement and benefit from structure, discipline, and comradery as a member of a team or working toward an individual fitness goal, some push themselves too far. For many, exercise serves as a coping mechanism that may be initially adaptive. However, they can ultimately feel the need to exercise with increasing frequency, intensity, and duration, perhaps to the point of injury. When injured, they push forward with their regimen or become wracked with frustration and anxiety. If life gets between them and a scheduled workout, they can experience emotional, even physical, withdrawal symptoms. Individuals relying on physical activity as a primary coping mechanism face the additional weight of emotional issues that led them to exercise, leaving them in even greater emotional turmoil and without adequate coping skills to adapt. Exercise comes to be the most important aspect of life, taking precedence over other responsibilities and wreaking havoc on their physical and mental wellbeing. For these patients, typical messages of encouragement to lead a healthy lifestyle are actually harmful.

²What is being described here is pathological exercise (PE). PE is currently not a diagnosable mental illness found in the DSM-5,² but it can be a symptom of an eating disorder (ED). PE has been described as either primary or secondary,³ as well as either an addiction or a compulsion. Primary PE exists without an accompanying ED or body dysmorphic disorder (BDD); thus the primary motivations to exercise are the rewards of exercise itself, including stress relief, improved self-image, and alterations in neurotransmitter release responsible for “runners’ high.” Secondary PE exists as a symptom of another disorder, usually an ED; the desire to exercise is secondary to the desire to lose weight or attain a leaner or more svelte physique. It is widely recognized that some with an ED adopt exercise as a maladaptive compensatory behavior to burn calories, but fewer realize that exercise can be problematic in the absence of an ED. Even if physicians can conceive of exercise in itself as potentially maladaptive, it can
be difficult to recognize when embodied by a young, healthy-appearing patient.

So how many are suffering from PE unbeknownst to their physicians and therapists? There is much uncertainty regarding prevalence, with estimates among adults ranging from 1.4% to 52%, depending upon the assessment technique and participant sample.\(^4\)-\(^6\) Many studies have targeted cross-country runners and other endurance athletes—populations where the proportion with PE would be much higher than the general population. To clarify, it is not the duration or intensity of the exercise itself that characterizes PE, but the mindset with which one exercises, the implosion of perceived wellbeing when unable to exercise, and the psychological need to continue excessive physical activity at the expense of physical health, social responsibilities, etc. Those who engage in endurance sports are at greater risk not only because the culture of those activities encourages pushing the body to its limits, but also because those activities serve as an outlet for individuals already using exercise as a coping mechanism or who are attracted to the properties that make it addictive. Organized sports serve as a “safe haven” for PE, as repeated injury, exhausting practices, and unhealthy body compositions are often accepted without question. One aim of our research\(^7\) was to shed light on its psychological underpinnings as addictive or compulsive. We also hoped to provide more accurate prevalence estimates for the general adult population, as well as estimates by gender and by specific ED diagnosis.

We administered six previously validated measures assessing various conceptualizations of PE\(^7\) and one measure of disordered eating, the Eating Disorder Examination-Questionnaire (EDE-Q)\(^8\) to a sample of 625 adult participants representative of the general population as well as to a sample of 872 athletes and avid exercisers. Our results suggest that the prevalence of PE in the general population may be as high as 6.4%, with a 5% prevalence estimate for secondary PE and 1.4% for primary PE.

Certain characteristics seem to increase patients’ risk for PE. For example, 14.6% of those with significant ED symptomatology may also have PE, and risk was highest in those with bulimia nervosa (BN). Additionally, it appears secondary PE more closely resembles a compulsion than an addiction. Overall, however, addiction and compulsion measures were strongly correlated with one another, suggesting motivation for excessive exercise may be conceived as both addictive and compulsive to varying degrees.

Athletes are at even greater risk than those with an ED, with 18.6% classified with PE versus 9.8% of non-athletes in our entire sample ($\chi^2[1] = 21.1, p <.001$). The measures assessed maladaptive thought processes surrounding exercise rather than exercise frequency or intensity alone. Thus, these results cannot be explained away by two-a-day practices. Interestingly, risk for developing PE does not differ significantly by gender, although females are more likely to display PE features in the context of an ED while males are more likely to have primary PE. Women scored higher on measures of compulsion while men scored higher on measures of addiction, suggesting that females are more likely to exercise compulsively in an effort to lose weight or manage anxiety, while males have a more addictive PE profile. It should be recognized, however, that body modification may be a motive for many males but was simply not captured by the questionnaires used in this study. This was supported by a prospective British study examining risk factors for compulsive exercise in adolescents, which not only reaffirmed the role of media pressure to be thin in the development of compulsive exercise in girls, but also found that family and peer messages to become more muscular predicted compulsive exercise in boys.\(^9\)

Although our research examined PE in the adult population, childhood and adolescence are critical periods during which coping mechanisms and self-concept are developed, healthy and unhealthy habits are formed and solidified, and engagement in physical activity through organized sports or other means is (rightfully) encouraged. The relatively few studies of younger populations further validate our concerns regarding this age group. One Italian study including 2,853 high schoolers iden-
“Red flags that could signal a maladaptive relationship with exercise: exercise with increasing frequency, duration, or intensity that takes priority over other activities and responsibilities; negative emotional or physical symptoms when unable to exercise; continuing to exercise despite injury or other contraindications; and exercising to modify a distorted body image.”

Tified “exercise addiction” in 8.5% and noted significant correlations with other compulsive and addictive behaviors. Researchers in Denmark developed a youth version of the Eating Addiction Inventory and reported a prevalence of 5.5% in adolescent athletes and 21.2% in patients with an ED among 452 participants aged 11-20 years.

How can you use this information to help young patients? The first step is recognizing that PE exists and can have a profound negative impact on your patients’ lives. Our results dispel the misconception that females with EDs are the only demographic with maladaptive exercise behaviors. If an adolescent boy mentions his commitment to working out, frustration with repeated injuries, or slipping grades and other abandoned activities, do not assume such attitudes and behavior are normal given his gender. Similarly, if a young lady presents with a very thin body habitus, do not feel relieved when you discover she is a cross-country runner, swimmer, or soccer player. PE can present in many forms: as compulsive or addictive, across genders, and alone or in conjunction with an ED. As with the diagnosis of any condition, societal norms and biases should be recognized and put aside to provide the best care for all patients. Physicians are not immune to having their own biases.

Unfortunately, it appears there is no single measure that can reliably identify PE, as only 41% of those with PE in our study scored high in more than one measure. You are thus tasked with the challenge of identifying potential red flags that could signal a maladaptive relationship with exercise: exercise with increasing frequency, duration, or intensity that takes priority over other activities and responsibilities; negative emotional or physical symptoms when unable to exercise; continuing to exercise despite injury or other contraindications; and exercising to modify a distorted body image. As with most important issues, young patients will not present you with this information without pointed questioning or collateral input. It is imperative to ask specifically about their relationship with exercise. How important is exercise? Why do they exercise? How do they exercise? What happens if they are unable to exercise? Asking a few simple questions will help you determine whether further discussion or intervention is warranted. Additionally, preventative steps should be taken with children and adolescents to address unhealthy messages surrounding physical appearance that are projected through various forms of media. Discuss the negative impact that media can have on body image with both children and parents; encourage parents to limit exposure as much as possible and talk with their children about the importance of health and other personal attributes over attaining a particular body composition. While it is important to encourage moderate physical activity given the current obesity epidemic, other coping skills should be fostered and family-based treatment (FBT) or cognitive-behavioral therapy (CBT) implemented when appropriate.

While the knowledge base on PE is growing exponentially, evidence supporting treatment modalities specific to PE is lacking. To date, there have been no randomized controlled trials examining treatment for primary PE. Thus, physicians and therapists must rely on addiction principles, encouraging abstinence or harm reduction. Standards of care are more clearly defined for patients with secondary PE, as there are many evidence-based treatments to address their underlying ED. FBT and CBT are currently viewed as the most effective modalities and can be tailored to encompass exercise behavior. Patients with anorexia nervosa (AN) should drastically reduce or eliminate exercise until weight is restored. Similarly, those with BN should minimize or eliminate exercise until they significantly reduce or stop their purging behavior,
as excessive exercise can contribute to the devastating cardiac consequences that result from electrolyte imbalances associated with this condition.

It is essential to fully understand patients’ motives to exercise in order to address maladaptive attitudes and cognitions, and to also treat any aggravating comorbid psychiatric illness, such as anxiety or depression. It should be noted that selective serotonin reuptake inhibitors (SSRIs) are not effective in the treatment of AN, as weight restoration must occur before SSRIs will produce their desired effects. Thus, other treatment modalities, such as FBT, CBT, inpatient re-feeding, and/or olanzapine, should be utilized in patients who are severely underweight.3,14 Treatment for PE is far from straightforward, and a full discussion of the nuances and unknowns is beyond the scope of this article. However, while the steps to recovery are not crystal clear, recognizing that excessive exercise can be problematic and may require intervention is a great place to start.

Take Home Summary

- Pathological exercise (PE) is an unhealthy relationship with exercise that, like other addictions or compulsions, profoundly impacts physical and mental wellbeing. It may be associated with an eating disorder or present independently.
- Our research suggests 6.4% of the general adult population and 18.6% of athletes may suffer from PE, and other studies report similar prevalence rates among adolescents, yet it remains largely unrecognized and undertreated.
- Given the prevalence of sports participation and eating and related disorders in the child and adolescent population, it is important that those caring for them recognize PE and intervene early to prevent the development of eating disorders and to restore global functioning and wellbeing.

References


About the Authors

Hayley Cunningham, BS, is a medical student at the University of North Carolina (UNC) Chapel Hill School of Medicine, class of 2019. She received her bachelor of science in psychology from Furman University, which funded her research referenced in this article. A passionate advocate for physical and mental wellbeing, she is the creator of Flourish, a UNC student organization that connects students with low-income community members to help them lead healthier lives. She has also educated teachers, health professionals, and children about the dangers of the “choking game” after losing her cousin to this deadly activity. More information at: http://cher.unc.edu/cher-team/hayley-elisabeth-cunningham/

Timothy D. Brewerton, MD, has been involved in the field of eating disorders since 1984 – not only as an experienced clinician, but also as a researcher, teacher, mentor, writer, and advocate. He is currently a clinical professor of psychiatry and behavioral sciences at the Medical University of South Carolina in Charleston, SC, where he is also in private practice. Dr. Brewerton is a Distinguished Fellow of the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, a Founding Fellow of the Academy of Eating Disorders, and a former president of the Eating Disorders Research Society. He has authored over 150 articles and chapters on eating and related disorders and has edited two books.

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We are proud to announce AACAP’s first ever Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award, made possible by a generous donation by the Marilyn B. Benoit, MD, Fund. This award seeks to provide an experiential opportunity to those interested in the fields of child welfare, foster care, and/or child maltreatment prevention/intervention.

The awardee receives $4,000 to facilitate the completion of a project lasting 12-16 weeks in which he or she collaborates with a mentor. Eligible applicants must be a child and adolescent psychiatry resident, child and adolescent psychiatry fellow, or early career psychiatrist within seven years of graduating from a fellowship program and have an interest in the field of child welfare, foster care, and/or child maltreatment prevention/intervention. Mentors must have experience in key issues in any of these areas, but they themselves do not need to be child and adolescent psychiatrists by training.

For additional information, please visit: www.aacap.org/CMMA or contact us at clinical@aacap.org.

Marilyn B. Benoit, MD, Child Maltreatment Mentorship Award

Deadline: April 16, 2018
Domestic Minor Sex Trafficking: A Call to Action

Anish Raj, MD

I met “Ashley” one March night in the pediatric emergency department. While initially reluctant to discuss her presenting circumstances, the 14-year-old brightened up when I shifted the conversation and asked what she aspired to be when she got older. She smiled and replied emphatically, “A pediatrician; I want to help kids.” While part of me is always warmed when I hear that a young person is interested in dedicating his or her life to serving children and adolescents, I immediately recognized that the odds were stacked against Ashley. She had not chanced upon the emergency department. Instead, she had been brought in by law enforcement for medical clearance after having been missing for the previous 3 weeks. A missing persons report had been filed with the local police department, and the chief complaint on her chart, per her mother, read, “Having sex with many different people at hotels.” The presentation was textbook for a case of domestic minor sex trafficking (DMST): history of running away, returning home with new clothes and accessories, posting sexually explicit images on social media, and staying with an older woman suspected of recruiting younger girls. After completion of the physical exam and laboratory work-up, I wished Ashley the best, and she was escorted out by law enforcement to the state juvenile detention center due to a pending bench warrant. As I watched her leave, I wondered if our paths would cross again in the future, and whether she would be able to achieve her dream of becoming a pediatrician.

The topic of DMST is one marred by preconceived notions and the propagation of misinformation. A comprehensive review published in 2013 by the Institute of Medicine and funded by the United States Department of Justice identified the following as the key barriers to the identification of exploited youth by healthcare providers: 1) a lack of understanding of commercial sexual exploitation and sex trafficking of minors; 2) potential complications related to mandated reporting; 3) the absence of standardized policies and protocols to guide practice; and 4) the hesitancy of many survivors to disclose. The reality that a trafficking victim could look like any American teenager whose vulnerabilities are identified and targeted through grooming tactics perpetrated by perverse but often charming exploiters has not yet been fully appreciated. Moreover, the misnomer of “child prostitute” that has wrongly been applied to many minor trafficking victims has only intensified the stigma. As Williamson and Prior write,

Ultimately, it may be necessary for a paradigm shift to occur in which the purchaser of sexual services from a child is no longer referred to as a john or a customer, but is instead referred to as a child sexual predator, as would be the case in any other instance in the United States when an adult seeks out sex with a child.

A recent survey of 109 pediatric attending physicians across a range of specialties noted that 83% had never received training on DMST. Only 32% had screened any patients for DMST in the preceding 12 months, while only 14% were aware of available resources that could be offered to a DMST patient. That study, along with others that have been conducted with similar findings, emphasizes the idea that healthcare providers cannot confront something that they themselves do not know about. What is especially troubling about providers’ lack of awareness is the frequency with which trafficking victims interface with a healthcare setting and are not identified: these brief moments of contact are akin to missed opportunities. A 2014 report found that almost 90% of adult and minor survivors had some form of contact with a healthcare provider in the preceding year while being trafficked. A retrospective analysis highlighting the demographics of confirmed and suspected DMST patients in Rhode Island registered a similar number (81%). While the literature base is slowly growing, the true scope of the issue at hand is unknown. No consensus exists on the
estimates of incidence and prevalence, likely secondary to the clandestine nature of the sex industry, variability in terminology, and lack of central databases. National epidemiological estimates continue to range from as low as 1,400 to as high as 2.4 million.¹

While psychotherapeutic techniques and effective pharmacologic agents have been identified for posttraumatic stress disorder, not much is known about the child and adolescent psychiatrist’s role in addressing DMST. Given the likelihood of repeated trauma exposure, recommended treatment modalities have largely been extrapolated from studies on other marginalized groups.⁶ However, the provision of mental health services is inherently limited for patients who are frequently absent from care. Nonetheless, what is clear is the association between DMST and mental health comorbidities. As Goldberg et al. demonstrated, a staggering 73% of their suspected or confirmed DMST pool reported a previous psychiatric diagnosis.⁵ Roughly 1 out of 2 endorsed a prior psychiatric hospitalization, history of suicidal ideation, and self-harm via cutting.⁵ I suspect there are few subgroups in the pediatric demographic that exhibit such high-risk qualities.

On a sobering note, I was recently made aware that Ashley was found to be unexpectedly pregnant. Only time will tell how the complexities of teenage pregnancy will reconcile with the multilayered nature of her narrative. In hindsight, what would the appropriate intervention have been? Simply identifying victims of DMST is not good enough. As advocates of mental health and general wellness, child and adolescent psychiatrists have the opportunity to champion the future. This will require providers first being open to learning about and identifying DMST, maintaining a nonjudgmental approach, ensuring a safe place to discuss circumstances and facilitate an appropriate disposition, and engaging with child protective services and advocacy opportunities.

As we all know, psychiatry has never excelled in a vacuum: efforts to ensure multidisciplinary teamwork and wraparound services are crucial. Healthcare providers should rally with local law enforcement and the legal system to advocate for trafficking survivors to be plugged into victim services instead of being prosecuted. The formation of state anti-trafficking coalitions, such as the Rhode Island Human Trafficking Task Force and New Jersey Coalition Against Human Trafficking, can be helpful in fostering these partnerships. Hospital protocols should be streamlined so that practitioners in any setting are equipped to identify and refer patients who they deem high-risk. While no brief screening tools have been nationally validated, several multisite studies are currently in process. In the interim, community health centers, like Asian Health Services in California, have taken steps to conduct research to enhance awareness about sexually exploited youth and implement screening and referral guidelines within their own facility.⁷ Child and adolescent psychiatrists should reach out and work in tandem with child protection services so that trauma-informed mental health services can be facilitated without delay. With the medical field moving towards integrated care models, it is imperative that pediatricians and psychiatrists collaborate with case managers and social workers to maintain all eyes on our most vulnerable youth. Let us build a safety net so that no child risks falling through the cracks. Ultimately, our children will best be served by evidence-based interventions that improve prevention, identification, and management of DMST and other forms of maltreatment. Until then, we can only hope that our provisional treatment options help break the cycle.

Take Home Summary
Youth involved in domestic minor sex trafficking should be identified as victims of sexual exploitation and offered services immediately. Appropriate mental health interventions have not yet been elucidated but will need to be, given the nature of the recurrent trauma.

References


### About the Author

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

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Call for Papers and Children’s Artwork

As part of an ongoing Call for Papers, JAACAP seeks high-impact papers on the mental health of children, adolescents, and families with a particular interest in our new article types for 2018, including Master Clinician Reviews, Commentaries, and Case Conferences.

Special Call for Papers on Depression

In conjunction with the presidential initiative of AACAP President Karen Dineen Wagner, MD, PhD, on depression, JAACAP and JAACAP Connect have issued a special call for papers on this timely topic. The series aims to cover current topics in depression, including but not limited to programs that have initiated depression screening for youth and processes by which youth who screen positive for depression receive treatment.

Call for Cover Artwork

JAACAP seeks interesting images and original artwork by children and youth, including but not limited to those who have personally struggled with mental health challenges. Submissions in which the artist reflects upon their identity, family, and/or community are particularly encouraged.

Questions and pre-submission inquiries should be directed to support@jaacap.org or connect@jaacap.org.
We are proud to announce AACAP’s first ever Psychodynamic Faculty Training and Mentorship Initiative, made possible by a generous donation by the Samuel and Lucille B. Ritvo Charitable Fund. The initiative aims to support and advance psychodynamic psychotherapy training in child and adolescent psychiatry residency programs through faculty development. Applications are open now through May 1, 2018.

Up to six awardees design psychodynamic training projects applicable to their child and adolescent psychiatry divisions. Applicants identify a problem or an area in need of improvement but are not expected to already know how to solve the problem. That will be worked out in collaboration with AACAP mentors.

The experience includes a networking event and a daylong training session during the week of AACAP’s 65th Annual Meeting, followed by the completion of a project through the subsequent year. A stipend of $350 is provided to cover travel support for attending the required events during the Annual Meeting.

CANDIDATES MUST:

- Have an MD, DO, or equivalent degree
- Teach in a child psychiatry, triple board, or post pediatric portal training program
- Be affiliated with an ACGME accredited training program
- Be an AACAP member or have a membership application pending at the time of submission

To learn more about the award and application process, visit AACAP’s Awards page at www.aacap.org/PFTMI. For questions, contact training@aacap.org.
Bullying in Child and Adolescent Psychiatric Training:
The Need for Identification and Prevention

Sara Pawlowski, MD

Case: A 26-year-old first-year psychiatry resident presents for rounds on her first day of a child consult-liaison rotation. She is anxious to begin the rotation because she will be working with an attending psychiatrist who is known as being difficult to please. The resident presents the case of a child in the emergency room to the attending, a second-year child and adolescent psychiatry fellow, and several medical students. The resident who is presenting the case begins to notice that the attending makes eye contact only with the fellow and then asks him to present the assessment and plan for the patient she just has presented. Using “herself as an instrument” to pick up on subtle interpersonal dynamics, the resident senses that the attending is annoyed with her and that she is not doing a good job on her first day.

Throughout the rotation, the attending often criticizes the resident and gives her consistently negative feedback in front of the group. She often feels embarrassed and inadequate. She tries harder and harder to please the attending and arrives hours early to prepare for rounds and thoroughly research her recommended treatment plans. Despite these efforts, the attending’s exclusion and criticism of her continue. She works diligently to make specific changes in response to the feedback offered, but there is no change to the criticism. She begins to resent the fellow for not explicitly supporting her and for being a seemingly passive bystander. The resident continues on the rotation and, all the while, feels a sense of unease. When electronic feedback from the attending and fellow arrives at the end of the rotation, it indicates that she has received below average marks without elaboration.

At the beginning of the next rotation, the resident notices a lingering impact of the previous evaluation on her general morale and self-esteem. She feels sad, unmotivated, and is having difficulty sleeping. The resident is unclear how and if in any justifiable ways these experiences have affected her personally and professionally. She also feels she should be resilient enough to handle better her feelings regarding the entire experience.

Questions to consider:

- Do the described interactions between the first-year resident, the fellow and the child consultation-liaison attending psychiatrist represent bullying?
- What is bullying in medicine?
- What can be done in psychiatry training programs to make for all a more positive work environment free of bullying?

Bullying in the Workplace

Bullying in any workplace is generally defined as “repeated acts and practices that are directed at one or more workers, which are unwanted by the victim, which may be done deliberately or unconsciously, but clearly cause humiliation, offense, and distress, and may interfere with job performance and/or cause unpleasant working environments”. According to a Joint Commission review, there are many factors that can contribute to bullying, including “systemic factors” (such as the unique health care environment, which often includes high-pressure, demands for productivity, and hierarchical structures that differentiate powerful players from non-powerful players) and individual factors (including one’s own vulnerabilities and challenges with interpersonal and conflict resolution skills).
In the literature, there exist two major forms of workplace bullying: overt and covert bullying. They differ both in how they target individuals and in how they are identified. Overt forms of bullying present as more obvious examples of deliberate aggression and include humiliation and belittling in public. On the other hand, covert forms of bullying are less obvious and more insidious. Examples of covert bullying include exclusion, “freezing out” and ignoring, or excessive monitoring of work. The introductory case vignette highlights both overt forms of bullying (harsh criticism, humiliation, and belittling) and covert forms of bullying (exclusion, freezing out, and ignoring).

One of the more challenging parts of bullying is understanding the victim's subjective experience, as some people may be more likely to regard sarcasm, innuendo and negative treatment as part of their own psychological tendencies. For example, a victim of bullying may generally be more susceptible to self-blame. The victim's subjective experience may also involve a “hostile attribution bias,” when, in the face of ambiguous communication, someone may assume the other is more hostile than the other intends to be.

Bullying does not just involve the dyad of the bully and the victim. Within the bullying dynamic are the bystanders who likely are aware of the bullying and affected by it, too. In this way, the team atmosphere suffers, as does each of the team's members. This is the phenomenon of “negative behavior contagion,” where the impact of bullying on one individual has a potential negative effect on others. Team members may be afraid to state their opinions or concerns. In medicine, this fear to speak up can present a risk for the patient, as team members might not raise appropriate questions or notify the attending of patient safety risks. The presence of bullying within a team also affects the learning of all members of the team, as trainees might be more likely to avoid asking or answering questions due to fear of experiencing directly the same bullying they have witnessed. Dr. Sheila White, a psychologist in the United Kingdom who has researched the psychodynamics of bullying, also postulates a theory called the “life cycle theory of bullying,” where these dynamics of bullying seem to repeat in one's professional and personal lives.

Thus, once a bully, often a bully, and once a victim, often a victim. It is not clear yet if this also is true for bystanders, as well, who may experience being both outside of and pulled into a bullying dynamic.

Bullying in Medicine

The topic of bullying in medicine came to the fore when the ground-breaking paper authored by Dr. Henry K. Silver and published in *The Journal of the American Medical Association (JAMA)* exposed medical education as guilty of bullying through medical student maltreatment. Since then, additional studies have explored in further detail the specific forms of bullying that occur in medicine. Chadaga, Villines, and Krikorian, the authors of “Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey,” surveyed residents and fellows of all specialties throughout the United States graduate medical education system to quantify participants' experiences with bullying during training. Alarmingly, almost half of the respondents (48%) reported being subjected to bullying. Among the study's participants, covert bullying was the most frequently reported bullying behavior; 44% identified covert bullying as one of the bullying behaviors they experienced in the course of their training. Residents and fellows also reported experiencing destructive innuendo and sarcasm (37% of those who experienced bullying) and attempts to humiliate (32% of those who experienced bullying). Of note, 61% of respondents reported having witnessed the bullying of others, which both underscores the prevalence of bullying and suggests that hostile attribution bias, alone, cannot account for the self-reported prevalence of bullying. Of note, this study’s findings for the psychiatry resident subgroup did not statistically differ from those of other specialties. Bullying is a pervasive problem throughout all specialties in graduate medical education—one from which, as psychiatrists, our particular training in interpersonal and group dynamics seemingly does not make us immune.

Implications for Psychiatric Training Programs

Although some may expect psychiatrists to be especially attuned to the forces that are at play in human
interactions and, as a result, possess the insight and ability to identify and prevent bullying in our education and training programs, as outlined above, this has not been shown to be the case. Although studies of workplace bullying done specifically in psychiatry training settings are very limited, there are two such studies: one of the National Health Service and another done in Pakistan as a cross-sectional study. These studies show that bullying behaviors in psychiatric training are pervasive. Bullying, to the likely surprise of many, is as much an issue in the workplace of psychiatrists and psychiatric trainees as it is in the workplaces of those in other medical specialties.

Our psychoanalytical training as psychiatrists may help us look deeper into the interpersonal dynamics that often are at play in bullying. Dr. White explains that Winnicott’s concept of containment and the holding environment are most useful in understanding bullying behavior. She sees that bullies often are trying to rid themselves of their stress and anxieties and to find someone else—frequently, the bullying victim—to act as a “container” of these negative feelings or negative projections. Trainees are vulnerable to becoming “containing” victims, particularly as they often search outside themselves for answers to inner questions such as, “Am I good enough in this role?” They are in a phase in their professional identity development that makes them inherently vulnerable to the influence of more powerful others.

When bullying does occur within our psychiatric training programs, there are consequences—personally and professionally—for the bullying victims and for our larger psychiatric training system. When residents are bullied, they report higher levels of depressive symptoms as measured by the Major Depression Inventory (MDI), including more changes in sleep and appetite, and lower self-esteem. Furthermore, bullying during training predicted increased depressive symptoms in impacted trainees both at one-year and three-years follow-up, including among those who were assessed after completion of their training. Based on this information, bullying in training can have mental health implications for a longer time than the duration of training, thereby negatively affecting those who make up our profession.

**Identification and Prevention of Bullying in Our Training Programs**

Given the detrimental impact that bullying can have on psychiatric trainees and the overall system, we need to increase awareness of bullying in medicine. However, multiple potential barriers to doing so exist. One potential obstacle to increasing the awareness of bullying is the finding that someone who has never been bullied is less likely to recognize bullying in his or her environment than someone who has been bullied. In the GME study on bullying, 97% of those who experienced bullying also reported witnessing it, while only 29% of participants who did not experience bullying witnessed it. Being subjected to bullying may “sensitize one to noticing it more frequently” in one’s environment. Another possible barrier to increasing awareness of bullying in psychiatric training is the potential assumption that, because psychiatrists are trained to be aware of power dynamics in the relationships in patients' lives, we should be able to identify such dynamics in the relationships in our own lives. The extension of such thinking would be that psychiatry, as a profession, should be at a lower risk for bullying in the psychiatry training workplace, but the above-described data do not support this. Denial or ignorance of the existence of bullying in psychiatry training may “form a lattice on which it can flourish.” This means that if the field of psychiatry does not increase its awareness and recognition of bullying in the workplace, then future trainees will continue to have to suffer its effects.

It may be useful to extrapolate knowledge gained in other work environments about the progression of bullying in order to both raise our own awareness and take action to it. In the workplace, bullying behaviors often progress through three phases of increasing aggression: “(1) ‘antilocation,’ characterized by prejudicial gossip restricted to a small ‘in-group’ circle and behind the back of the victim, (2) avoidance of the victim by the crowd and associates, and, at later and more advanced malignant stages, (3) open harassment of the victim...
including discrimination, alienation, exclusion, offensive remarks and jokes.” Bullying can occur in stages that can progress towards more and more detrimental behaviors, and, thus, identifying these behaviors at an earlier phase can prevent the development of more overt forms of bullying. With this knowledge, gossiping or avoidance may be viewed as red flags for eroding relationships in a team or program. As a trainee, trainer, or program director, just being able to recognize these behaviors and openly talk about them can be a first step to preventing more significant bullying from occurring. The person doing the bullying may not be aware of the level of harm that is occurring from his or her actions or even recognize the actions as bullying. At the level of the program, starting a conversation with staff, faculty, and trainees about these bullying phases and the impact of bullying on trainees can be a concrete way to start to address bullying in our workplaces.

Changes can be made at both the individual and system levels to address bullying. In an article, “Creating a Culture of Mutual Respect,” the authors state that many hospital policies address overt mistreatment such as discrimination, criminal activity, sexual assault or physical abuse, but that grey areas such as bullying still need to be addressed with more formal organizational structures for reporting and follow-up. These include: creating a code of mutual respect that encourages sensitivity and awareness to the causes of inappropriate behavior; establishing a system for mediating, tracking and addressing these issues; providing trainings for staff; developing a formal accountability process; and measuring the results.10

The AWARE study further identifies “awareness of what entails workplace abuse and how to report it” as “the first steps,” but also offer other concrete suggestions as well (see Table 1).

With almost half of trainees in graduate medical education reporting experiences of being bullied, bullying in medicine and, specifically, in psychiatry training, warrants more understanding and exploration. The full impact of bullying on the performance of trainees in the health care profession still is not clear. What is clear is that bullying does occur within psychiatry training; it frequently is present in many hierarchical workplaces. In addition to studying the impact of bullying in medicine on health care and training, we need to study how to prevent it. Bullying is a problem, but, perhaps, as a field, we can better use our psychiatric training and skills in understanding interpersonal dynamics to help us identify and prevent it in our psychiatry training systems.

### Take Home Summary
- Bullying can exist in overt and covert forms in the workplace.
- There is a growing body of evidence that confirms the existence of and impact of bullying in medicine.
- Child and adolescent psychiatry trainees may be more at risk of covert bullying than of overt bullying, but covert bullying can still have negative impact on the mental health of trainees.
- Next steps need to include looking into how we prevent bullying from occurring to child and adolescent psychiatry trainees.

### Table 1: Summarized Points from AWARE Study

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<table>
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<tbody>
<tr>
<td>1.</td>
<td>Offer to residents well-being resources to counter the potential pull into bullying victim roles.</td>
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<tr>
<td>2.</td>
<td>Offer to staff training modules that address various aspects of interpersonal interaction. The authors specifically recommend modules on “emotional intelligence, communication, leadership skills, assertiveness training, burnout, conflict management, stress relief, etc.”</td>
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<tr>
<td>3.</td>
<td>Ensure that those in leadership roles are “supportive, impartial, and available” to both residents and staff so that concerns can be discussed effectively.</td>
</tr>
<tr>
<td>4.</td>
<td>Work to support an atmosphere that “allow[s] mindful awareness of one’s capabilities, encouraging seeking of help without the implication of weakness.”</td>
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<tr>
<td>5.</td>
<td>Standardize feedback for trainees across settings.</td>
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<tr>
<td>6.</td>
<td>Develop with staff members in all roles an action plan to prevent bullying. Consider developing a committee to review incidents of potential bullying.</td>
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References


About the Author

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April 8-9, 2018

AACAP’s Legislative Conference and Assembly Meeting will take place in Washington, DC, from April 8-9, 2018. Join us for both events to advocate for children’s mental health.

**AACAP Legislative Conference**

On April 8 and 9, 2018, learn about the legislative process and public policy issues impacting child and adolescent psychiatry. AACAP’s Government Affairs team will provide you with advocacy materials to help develop and deliver the most effective message. Once again, family advocates will be invited to join AACAP members on Capitol Hill. Join us and make your voice heard as we advocate for children’s mental health.

Visit [www.aacap.org/LegislativeConference](http://www.aacap.org/LegislativeConference) for more information or contact Zachary Kahan, Advocacy & PAC Manager, at zkahan@aacap.org or 202.587.9669.

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Visit [www.aacap.org/Assembly](http://www.aacap.org/Assembly) for more information or contact Megan Levy, Executive Office Manager, at mlevy@aacap.org or 202.966.1994.
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Authors are strongly encouraged to submit an initial outline to the editors, so that early feedback and guidance can be provided prior to the development of a full manuscript. An invitation to submit does not ultimately assure acceptance of the manuscript.

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