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Welcome to JAACAP Connect!

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

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

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

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

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

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

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

Start Thinking About Authorship With JAACAP Connect
What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome, and you are invited.
13% of youth ages 8 to 15 have a mental illness severe enough to cause significant impairment in day-to-day living.

79% of children ages 6 to 17 with mental illnesses do not receive treatment.

50% of students age 14+ with mental illness drop out of high school (the highest rate of any disability group).

More than 4,600 youth die by suicide annually, yet experts believe nearly 80% are preventable.

Studies indicate on average the delay between first onset of symptoms and treatment is 8 to 10 years.

50% of all lifetime cases of mental illness are diagnosed by age 14.

JOIN US ON OUR BIKE RIDE ACROSS THE NATION AND HELP US BREAK THE CYCLE OF CHILDREN’S MENTAL ILLNESSES

Children’s mental illnesses are real, common, and treatable. We need your support to help spread the word. Visit BREAKTHECYCLE.AACAP.ORG and make a donation, take the pledge, or sign up to ride.
Receiving the Torch

I write this introduction, my first as editor of Connect, with both excitement and a sense of privilege. I have greatly appreciated the opportunity over the previous one-and-a-half years to work alongside Michelle Horner (Connect’s founding editor), the Connect editorial board, and the broader JAACAP team, to establish Connect as it is today. As a child and adolescent psychiatry residency training director, I value the mission of Connect, which 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. I applaud all of the authors, readers, and editorial team members who make Connect possible.

It is my pleasure to introduce this issue of Connect, the articles of which outline the ever-expanding scope of our practice as child and adolescent psychiatrists and encourage us to broaden our efforts beyond the four walls of our offices, clinics, and hospitals.

Robles-Ramamurthy and colleagues (p. 5) echo the presidential initiative of AACAP President Gregory K. Fritz, MD,1 and encourage all child and adolescent psychiatrists to recognize the responsibility we share to become involved in larger-scale advocacy efforts—ones that extend beyond the individual patient. In reviewing the particular vulnerabilities and mental health needs of unaccompanied Latino immigrant children, the authors encourage us all to raise the torch higher: “Social justice and policy issues are well within the scope of practice for those who care for and promote the well-being, development, and mental health of children. These issues are important to public health and clinical practice as well as to global child psychiatry, imperatives to which we are all held accountable.” They also charge us and our institutions of higher learning and training to educate trainees about social justice and policy issues, to model the inclusion of advocacy efforts in the practice of our profession, and to encourage and facilitate our trainees’ early involvement in such efforts.

Wagner and Gleason (p. 8) next bring to light the vulnerabilities of children with histories of prenatal substance exposure (PSE) and their families. They highlight the important role that we, as child and adolescent psychiatrists, can play through the provision of education to parents and families about the effects of PSE and the ways in which the parents can work to mitigate these effects through the caregiving environment. Wagner and Gleason encourage us to empower families with such knowledge, to combat the stigma of substance use disorders, to advocate for policies and services that may reduce PSE, and to call for further research that investigates both the effects of drugs of abuse on brain development and potential interventions for children affected by PSE.

Sinyor and colleagues (p. 15) challenge us to think creatively about ways to provide primary prevention of mental illness. They propose that the third book in J.K. Rowling’s series (Harry Potter and the Prisoner of Azkaban) may serve as a ubiquitous, engaging, and largely untapped resource through which to increase middle-schoolers’ mental health literacy and to teach basic cognitive-behavioral therapy skills that might prove universally beneficial and protective against the development of future clinical difficulties.

Rounding out this issue, Masters (p. 22) reminds us of potential limitations to the frequently perceived sanctity and inviolability of our professional four walls and associated clinician–patient confidentiality. He reviews the Tarasoff rulings and highlights circumstances in which our responsibilities may extend beyond our patients to include protecting others. He recommends that any such intervention provide the least possible disruption to the therapeutic relationship while effectively fulfilling our potentially dueling responsibilities.

Our current world is an extremely dynamic place. While the (increasingly) expansive scope of child and adolescent psychiatry may seem intimidating at times, the
clear and broad need for our professional expertise wards off complacency and provides exciting opportunities for us to reach out and connect with diverse and, at times, unexpected allies. The tensions that may arise as we consider the well-being of the patient/family in front of us, of the community and populations outside of our workplace, and of our ourselves can be challenging. However, with increasing awareness of these potentially competing demands and associated deliberate thought and action, we perhaps may be more able to establish and assert our positions with growing balance and comfort.

Through this issue and those to come, I look forward to working with you all to promote Connect’s ongoing evolution and to ensure its pertinence to the development of authorship and to the reading clinicians’ practice of child and adolescent psychiatry.

Oliver M. Stroeh, MD
Editor, JAACAP Connect

Reference
AACAP Award Opportunities
FOR MEDICAL STUDENTS, RESIDENTS, AND EARLY CAREER PSYCHIATRISTS

RESIDENTS AND JUNIOR FACULTY

AACAP Pilot Awards
2017 applications are closed. Stay tuned for 2018 updates.
Provides $15,000 to members with a career interest in child and adolescent mental health research
- Research Award for Child and Adolescent Psychiatry Residents and Junior Faculty, Supported by AACAP
- Research Award for Child Psychiatry Residents and Junior Faculty focusing on Attention Disorders and/or Learning Disabilities, Supported by AACAP’s Elaine Schlosser Lewis Fund
- Research Award for General Psychiatry Residents, Supported by Pfizer and Arbor Pharmaceuticals

AACAP Educational Outreach Programs (EOP)
Application Deadline: June 30, 2017
Provides the opportunity for residents to travel to AACAP’s Annual Meeting
- EOP for Child and Adolescent Psychiatry Residents, Supported by the AACAP Endowment, AACAP’s John E. Schowalter, MD, Endowment Fund, and AACAP’s Life Members Fund
- EOP for General Psychiatry Residents, Supported by the AACAP Endowment

AACAP Systems of Care Special Program Clinical Projects Scholarship,
Co-sponsored by SAMHSA’s Center for Mental Health Services and AACAP’s Community-Based Systems of Care Committee
Application Deadline: June 30, 2017
Provides support of $750 to attend AACAP’s Annual Meeting and present a poster on a systems-of-care-related topic

AACAP Junior Investigator Award, Supported by AACAP’s Research Initiative
2017 applications are closed. Stay tuned for 2018 updates.
Provides $30,000 a year for two years for one child and adolescent psychiatry junior faculty

MEDICAL STUDENTS

AACAP Medical Student Summer Fellowships
2017 applications are closed. Stay tuned for 2018 updates.
Provides a $3,500 to $4,000 stipend for 12 weeks of research training and covers travel expenses for AACAP’s Annual Meeting
- AACAP Jeanne Spurlock Minority Medical Student Research Fellowships in Substance Abuse and Addiction, Supported by the National Institute on Drug Abuse (NIDA) and AACAP’s Campaign for America’s Kids (CFAK)
- AACAP Summer Medical Student Fellowship Program, Supported by CFAK

AACAP Life Members Mentorship Grants for Medical Students
Application Deadline: June 30, 2017
Provides a travel grant of $1,000 for medical students to travel to AACAP’s Annual Meeting and network with leaders in the field

*All awards contingent upon available funding.
AACAP Distinguished Member Award Opportunities
2017 applications are closed. Stay tuned for 2018 updates.

AACAP Cancro Academic Leadership Award for master educators, which is offered in odd-numbered years, recognizes a currently serving Associate or Full professor, Chair, Dean, or equivalent rank for outstanding and sustained contributions to child and adolescent psychiatry education through teaching, mentorship, scholarship, and leadership.

AACAP George Tarjan, MD, Award for Contributions in Developmental Disabilities recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the understanding or care of those with intellectual and developmental disabilities.

AACAP Irving Philips Award for Prevention recognizes a child and adolescent psychiatrist and AACAP member who has made significant contributions in a lifetime career or single seminal work to the prevention of mental illness in children and adolescents.

AACAP Norbert and Charlotte Rieger Psychodynamic Psychotherapy Award recognizes the best published or unpublished paper written by an AACAP member using a psychodynamic psychotherapy framework.

AACAP Robinson-Cunningham Award recognizes the best manuscript written by a resident during child and adolescent psychiatry training.

International Scholar Award Opportunities
Application Deadline: July 14, 2017

AACAP Paramjit Toor Joshi, MD, International Scholar Awards recognize mid-career international physicians who primarily work with children and adolescents providing mental health services outside the United States.

AACAP Ülkü Ülgür, MD, International Scholar Award recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents.

For details about all awards, eligibility requirements, and for access to applications and nomination information, visit www.aacap.org/awards.
Unaccompanied Latino Minors, Immigration, and Mental Health: An Opportunity for Advocacy

Barbara Robles-Ramamurthy, MD, Milangel T. Concepcion Zayas, MD, MPH, Lisa Fortuna, MD, MPH, MDIV

Child and adolescent psychiatrists (CAPs) have a duty to be patient advocates in multiple ways. Indeed, the Child and Adolescent Psychiatry Milestone Project’s inclusion of advocacy within the systems-based practice competency recognizes this role as a core element of practice. However, while training programs focus on teaching advocacy for individual patients’ needs, such as securing insurance coverage for medical treatment or obtaining school accommodations, preparedness in public policy and social justice domains is often limited. Accordingly, the current president of the American Academy of Child and Adolescent Psychiatry (AACAP), Dr. Gregory Fritz, has highlighted advocacy as one of four areas that his presidential initiative on integrated care will tackle. The main goals of this article are to discuss the role of CAPs in advocacy efforts as they apply to the vulnerable population of unaccompanied children from Central America, to discuss ways in which CAP training programs can promote the special interests and advocacy efforts of their trainees, and to encourage all CAPs to consider ways to amplify their voices and roles as children’s advocates.

Child Migration: History of the Problem

Between 1850 and 1930, more than 100,000 children were sent from the northeast of the US to rural areas; while some families were looking to adopt a child, many families saw these children as aid for manual labor. These children, placed on “orphan trains” by their parents or by welfare agencies due to homelessness, were victims of poverty, culminating in their being sold or offered to farmers. Meanwhile, in the early 1960s, fearful parents wishing for a better future for their children outside of an antidemocratic government sent more than 10,000 children from Cuba. The current child migrant crisis in the US involves unaccompanied minors fleeing violence in Honduras, El Salvador, Guatemala, and Mexico. While unaccompanied children from Latin America have been crossing the border in smaller numbers for decades, largely unnoticed by the media, the issue has been publicized due to the increased volume of child migrants apprehended at the US–Mexico border. The humanitarian crisis prompting this exodus is unique in that it is a chronic and gradual forced displacement, in contrast to the high-acuity mass migrations associated with natural disasters or violent conflicts.

Mental Health Implications

Though limited systematic research has focused on the psychological experience of immigrant children, these minors are at high risk of trauma and harm. Many would meet legal criteria for asylum if they had an opportunity to tell their stories. The report by the United Nations High Commissioner for Refugees in 2014 notes that almost 50% of displaced children shared experiences of violence associated with organized crime, including drug cartels, gangs, or governmental corruption. In a Mexican sample, 38% of children reported having been recruited into and exploited for human smuggling. These stressors, coupled with those experienced during the immigration process, predispose them to substance use, anxiety, and adjustment disorders. Upon reunification, stressful living conditions can hinder the capacities of parents to nurture their children’s socioemotional development.

How the children experience separation from family members, the social conditions in their home countries, their immigration experiences, and the new environments and opportunities upon arrival in the US will influence their development and adaptation. Even
Unaccompanied Latino Minors, Immigration, and Mental Health

after arrival in the US, where they are seeking refuge, they continue to experience stressors added by the uncompassionate nature of our systemic immigration procedures. Additionally, given their language barrier, frequent lack of insurance, and high rates of placement in the foster care system, most of these children will not have the opportunity to seek and obtain needed mental health care. Depending on the clinical system and location in which they practice, CAPs may rarely interface with immigrant Latino children and other vulnerable populations, who are at the highest risk of psychiatric illness; the vulnerability of this population is therefore greatly worsened as their needs are under-recognized and often ignored by the health care system.

Opportunity for Advocacy

Children have rights, and it is our duty as health providers to foster policies and interventions in their best interest. Children coming from Central America or elsewhere should be protected in America. The high barriers they face to receiving mental health care and to maintaining mental health, as we have illustrated, require our advocacy to lower. Reform and progress do not happen by themselves. Whenever we stand up for an individual child or for a family, an extra step is needed to extend our actions into the larger community. CAPs have unique expertise in child development that should be brought to bear in educating policymakers dealing with the vulnerable population of unaccompanied Latino minors.

Our colleagues from the American Academy of Pediatrics (AAP) have set forth outstanding examples of promoting advocacy activities among members.7 We are grateful that, in these times of political discord, AACAP’s political action committee has encouraged members to engage in social policy activities. Dr. Fritz’s address to AACAP in January 2017 regarding the proposed immigration ban demonstrates AACAP’s commitment to the humane treatment of all individuals “without regard to their race, religion, ethnicity, or immigration status.”8 We are grateful that his message expanded past the effect of the immigration ban on the medical workforce into the greater needs of immigrant communities as a whole.

High-level advocacy is also illustrated by AACAP members Dr. Andres Pumariega and Dr. William Arroyo through their participation in an advisory committee created by the US Immigration and Customs Enforcement agency (ICE), which provided recommendations to improve detention practices of undocumented immigrant children and families. Their report notes that the detention of migrant children and families by the US government has been “controversial since its inception,” and lists evidence-based recommendations for a more humane approach to detention practices for children and families. Most noteworthy was their primary recommendation that family detention be discontinued, stating that it should be presumed that “detention or the separation of families for purposes of immigration enforcement or management is never in the best interest of children.”9

A Path Forward

Following the examples of these AACAP leaders, CAP trainees and training programs must also focus on advocacy. The process begins by engaging in self-reflection about one’s biases, lack of experience in navigating complex systems, interest or disinterest in advocacy, and knowledge about how one’s own skills and abilities are best utilized. Training programs can promote advocacy by creating opportunities for trainees. For example, training programs may develop clinical rotations tailored to the trainee’s interest. Partnerships with other professionals such as lawyers, politicians, and organizational leaders can promote the development of leadership skills in public health efforts. Additionally, exposure to CAPs involved in advocacy or those working in the public sector is important, thus creating mentorship opportunities. We have found such mentors by engaging with AACAP and APA committees and attending committee meetings, conference calls, or other events, such as the AACAP Legislative Conference, creating opportunities to develop requisite leadership and advocacy skills.

Colleagues previously published in JAACAP verbatim accounts from refugee children to beautifully describe why it is imperative that CAPs continue their advocacy
and compassionate care to immigrant populations. They state that “one of the most pernicious effects of the politicization of immigration has been to obscure the humanity of those children traveling to this country.”

These children’s integral well-being and their human rights are at stake. Silence and neutrality are not options for those working with developing human beings. Social justice and policy issues are well within the scope of practice for those who care for and promote the well-being, development, and mental health of children. These issues are important to public health and clinical practice as well as to global child psychiatry, imperatives to which we are all held accountable.

Take Home Summary

Child and adolescent psychiatrists have an ethical responsibility to promote access to quality mental health care for vulnerable populations, such as unaccompanied Latino immigrants. Dr. Fritz has focused on advocacy during his presidency. We urge CAP training programs to promote advocacy efforts and for trainees to join AACAP committees so that CAPs can have a larger impact at the population level.

References


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Disclosure: Drs. Robles-Ramamurthy, Concepcion Zayas, and Fortuna report no biomedical financial interests or potential conflicts of interest.
Talking to Parents About Behavioral Problems in Children Following Prenatal Illicit Substance Exposure

Elizabeth Wagner, BA, and Mary Margaret Gleason, MD, FAAP

**Case:** A 36-month-old girl with a reported history of prenatal substance exposure is brought to an outpatient pediatric clinic to establish care and receive immunizations to enroll in daycare. The father reports that he became custodial parent of the child in the past week, following the mother’s arrest for possession of an illegal substance. Previously, the child lived in another state with her mother and had limited contact with him. He is unaware of her medical history. When he brings her to the clinic, she is wearing her nightgown, and her hair is not brushed. She makes little eye contact and sometimes appears to actively avert her eyes. At the mention of her mother, she becomes more agitated, crying and tearing at the exam table paper, but uses few words. Her general physical exam is otherwise benign. Her father notes that he can’t get her to talk and that he is overwhelmed by her screams and tantrums. He wonders if her behavior is due to prenatal drug exposure, since her mother was “taking something” while she was pregnant.

Medical professionals are likely to encounter a situation similar to the one above during their careers given that prenatal substance exposure (PSE) continues to affect many infants born in the US. Negative outcomes from PSE are varied, with the potential to cause significant harm. PSE can lead to short-term sequelae such as low birth weight, intrauterine growth restriction, and neonatal abstinence syndrome (NAS), a form of opiate withdrawal. Long-term outcomes can include behavioral and cognitive problems and early initiation of substance use. Rates of PSE are difficult to estimate accurately because of stigma associated with reporting and inconsistent screening practices. Despite these difficulties, estimates exist for the proportion of children in the US who have been exposed prenatally to an illicit substance such as marijuana, opioids, cocaine, and methamphetamine (see Table 1). For example, among a nationwide sample of approximately 70,000 randomly selected individuals in the US, 4.7% of pregnant women interviewed reported use of an illicit substance within the last month. For perspective, consider the rising incidence of neonatal abstinence syndrome, an outcome associated with prenatal opiate exposure. According to a study conducted using two nationwide inpatient databases, the incidence of infants born in the US showing signs of NAS has been rising since 2000, from 1.2 per 1,000 live births in 2000, to 3.4 per 1,000 in 2009, and 5.8 per 1,000 in 2012.

While perinatal outcomes following prenatal drug exposure have been fairly well documented, research of long-term outcomes is more limited and includes neuro-behavioral outcomes posing significant implications for clinicians, including child and adolescent psychiatrists, caring for children with a history of PSE. This article will discuss examples of large cohort studies and the methodological challenges, then describe psychoeducation statements clinicians can use based on current knowledge of long-term neurodevelopmental outcomes for children exposed prenatally to illicit substances. We will then share clinical and policy implications, as there are substantial opportunities in our field to advo-

<table>
<thead>
<tr>
<th><strong>PREGNANT WOMEN %</strong></th>
<th><strong>NONPREGNANT WOMEN %</strong></th>
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<tbody>
<tr>
<td>Illicit drugs</td>
<td>4.7</td>
</tr>
<tr>
<td>Illicit drugs other than marijuana</td>
<td>1.8</td>
</tr>
<tr>
<td>Tobacco products</td>
<td>13.9</td>
</tr>
<tr>
<td>Alcohol</td>
<td>9.3</td>
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*Note: Table data were adapted from 3.
Methodologic Issues in PSE Research

There are multiple challenges in studying long-term outcomes related to PSE. Self-report of substance use by mothers may be an inaccurate report of fetal exposure due to a number of factors, including issues with underreporting due to lack of knowledge of exact substances used, difficulties recalling dose, recall bias, reliability of estimates of conception dates, and disclosure of a highly stigmatized, reportable, and potentially illegal activity. The timing of exposure affects outcomes variably depending on stages of fetal development during the PSE. Polysubstance use reporting complicates interpretation of outcomes since it is difficult to link specific exposures to specific outcomes. Studies of polysubstance use generally control for concurrent use statistically rather than in vivo. Prospective longitudinal cohort study designs necessary for long-term follow-up are limited by attrition (i.e., loss of some of the sample over time), and outcome may be affected by prenatal and postnatal environmental risk factors, which may moderate or mediate effects on the study outcomes.

Despite these challenges, a number of rigorous cohort studies reveal valuable findings about this population. For example, reviews indicate 14 different cohorts are included in studies of the effects of prenatal cocaine exposure on the developing child, including the Maternal Lifestyle Study, which has followed 1,000 children from birth into adolescence and young adulthood. The Infant Development, Environment and Lifestyle Study (IDEAL) is the only study currently in the US describing the effects of prenatal methamphetamine exposure and includes 320 children followed up to 7 years of age to date. Studies of opioid exposure show little consensus on long-term outcomes in children. Of the data that exists, methadone exposure is the most robust; however, there is a dearth of research specifically examining the effects of prenatal exposure to opiate prescription medication on long-term outcomes on development. The existing cohorts provide valuable information to describe the behavioral effects of prenatal drug exposure on the developing child, albeit with limitations.

PSE Outcomes for Children and Talking Points for Families

The following section reviews the literature on PSE and outcomes in offspring, focusing on 1) perinatal outcomes, 2) longer-term psychiatric outcomes, and 3) caregiving environment. Each section is followed by a summary of clinical talking points that can be used to help families like the one presented above.

1. Perinatal Outcomes

Neonatal outcomes of PSE vary to some degree by substance but can include low birth weight, intrauterine growth restriction, NAS after opioid exposure, and other neurobehavioral effects (see Table 2). The signs of NAS are summarized in Table 3. Taken together, infants with PSE may be more difficult to soothe, and parents may find it harder to interpret the infant’s cues. Importantly, perinatal outcomes may be affected by other prenatal risk factors associated with PSE, including concomitant use of licit substances such as tobacco and alcohol, poor nutrition, physical or mental health problems, and environmental stressors including violence exposure.

Clinical talking point: As a group, babies exposed to substances during pregnancy are at higher risk of some problems immediately after birth. However, not all babies show these problems. The specific risks for each child depend on a combination of factors that include the substance exposure, but also other prenatal experiences and factors.

### Table 2: Signs of Neonatal Abstinence Syndrome

<table>
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<tr>
<th>Sign</th>
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<tbody>
<tr>
<td>Increased muscle tone and activity</td>
</tr>
<tr>
<td>Seizures</td>
</tr>
<tr>
<td>Sweating</td>
</tr>
<tr>
<td>Nasal flaring</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Feeding problems</td>
</tr>
<tr>
<td>Diarrhea</td>
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</tbody>
</table>

Note: See Behnke et al. for further information.
2. Longer-Term Psychiatric Outcomes

The long-term psychiatric outcomes for these children are complex, with both biological and environmental processes likely contributing to risk and resilience.

In their review of follow-up studies of children with prenatal drug exposure, Lester and Lagasse identified 42 studies published between 1996 and 2008 specifically looking at prenatal exposure to cocaine (PCE), methamphetamine, and opiates.6 In studies that controlled for confounding factors, PCE was associated with adverse outcomes in language, attention, externalizing behavior, and cognition. The Maternal Lifestyle Study (MLS)10 demonstrated the dose-dependent effects of PCE on emotional and behavioral problems. Heavy prenatal cocaine exposure was associated with an increase in the prevalence of internalizing, externalizing, and total problems in children between 3 and 7 years of age (21% vs. 16%). Importantly, despite the high media attention to cocaine exposure,11 the combined effects of prenatal and postnatal alcohol and tobacco were stronger than that of heavy cocaine abuse for all ages. It should be noted that the increased rates of adverse behavioral effects with PCE compared with non-exposed children were not evident until age 5, and that life events are strongly associated with behavioral presentation.12

Since that review in 2010, prenatal cocaine exposure in the MLS has also been shown to be related to a need for special education services at 7 and 11 years old, especially in children with psychopathology, a finding replicated in other but not all studies.13 There is a suggestion that behavioral dysregulation patterns are moderated by gender; however, findings are mixed.14 New research focuses on the role of the parasympathetic system and the hypothalamic-pituitary-adrenal axis as a mediator of dysregulation patterns.15

In the major study of prenatal methamphetamine exposure (PME), the IDEAL study, PME had no association with behavior problems at age 3, but was indirectly associated with emotional and behavioral problems at age 5, which was associated with executive functioning problems at age 6½.7 The association between PME and emotional and behavior problems at ages 5 and 7.5 was fully mediated by early adversity, measured at 5 time points before age 3, meaning that early adversity explains the variance in behavior problems, not the biological central nervous system effects of the methamphetamine exposure (see Figure 1). Methamphetamine exposure is, however, associated with the risk of experiencing early adversity. This study highlights the potential for interventions that target the risk of early adversity in children with PME to reduce emotional and behavioral sequelae associated with PME.

Studies focused on opiate exposure alone are more limited by sample size and less rigorous control for...
confounding factors, but suggest the possibility of cognitive and emotional associations with the exposure.\textsuperscript{16}

In the MLS, examining all PSE together, PSE predicted increases in behavioral dysregulation across adolescence directly, and indirectly was associated with increases in executive function difficulties.\textsuperscript{17} This indirect relationship was mediated by early adversity and behavioral dysregulation. Controlling extensively for potentially confounding variables, adolescents with PCE show persistent behavioral dysregulation and associated early substance use by age 16 compared to non-PCE youth (27.9\% vs 19.9\% in the MLS) and especially with higher rates of marijuana use (39.6\% vs 16.3\% in a smaller study).\textsuperscript{18,19} A similar pattern of early substance use has been reported in youth prenatally exposed to marijuana.\textsuperscript{20}

Taken together, these studies suggest that children with PSE have higher rates of behavioral problems, executive function difficulties, and early substance use and that early adversity is an important mediator in some of these associations.

**Clinical talking point:** As a group, older preschoolers, school-age children, and adolescents who were exposed to illicit substances during pregnancy may have higher than usual rates of difficulty with paying attention and disruptive behaviors compared to other children their age.

### 3. Caregiving Environment

The current studies demonstrate that the caregiving environment plays a significant role in the behavioral outcomes of children exposed prenatally to drugs of abuse. As above, despite higher rates of some adverse behavioral outcomes, behavioral problems, executive function difficulties, and early substance use occur in a minority of children with PSE. Studies of behavioral and cognitive outcomes suggest early adversity, whose converse is a positive caregiving environment, appears to be a primary mediator of the association between PSE and behavioral dysregulation,\textsuperscript{17} suggesting quality caregiving can help ameliorate the risk for behavioral problems. One component of early adversity is a measure of the caregiving environment itself (the home) along with other components that shape a child’s safety and a parent’s ability to offer sensitive caregiving.

**Clinical talking point:** Despite the risk of difficulties children exposed to substances in utero may have, a supportive caregiving environment can be powerful and help a child develop the strengths and skills to overcome...
these potential challenges. Prenatal exposure to drugs does not have to define the child’s life.

**Clinical and Policy Implications**

The extant literature suggests that children exposed prenatally to drugs of abuse exhibit more problem behaviors and attention problems than their non-exposed peers, although a minority of children develop these clinical-level problems. The studies also demonstrate the importance of the caregiving environment in shaping behavioral regulation. The caregiving environment, especially protection from early adversity including ongoing substance use, violence, maltreatment, and symptoms of parental psychopathology, has a significant effect on the behavioral outcomes of children exposed to drugs of abuse prenatally. The finding that the caregiving environment offers protection is important since factors that contribute to the caregiving environment are responsive to change, and offer points of engagement for intervention in the lives of children.  

Existing literature demonstrates the substantial influence of other factors, including influences at the individual, family, community, and society level, in the clinical outcomes of children exposed to illicit substances prenatally, as represented in Figure 2. Individual-level factors are controlled for in the studies reviewed above; however, these factors can have a substantial influence on a child’s life. Public policy interventions can be developed to engage factors at all levels (individual, family, community, and society) and to promote resilience in children exposed to drugs of abuse prenatally.

For example, intervening at the family level, physicians and other health care providers are in a position to support parental treatment for substance abuse disorders and treatment for concurrent psychopathology. According to the National Survey on Drug Use and Health, even though women who discover they are pregnant tend to reduce their previous use of drugs, alcohol, and tobacco, most resume use following delivery. Therefore, pregnancy and following delivery is an ideal time to support parents in maintaining or working towards sobriety with clinical treatment and engagement of natural supports. Screening for substance use is an important topic of conversation at all postpartum healthcare-related visits.

Child psychiatrists can play an important role in educating parents about the effects of prenatal substance exposure when seeing children who may have been exposed to PSE. This education includes acknowledging the known physical, developmental, and mental health effects of PSE as well as debunking myths that suggest that PSE fully determines a child’s

![Figure 2. Social–ecological model of factors influencing psychiatric outcomes following prenatal substance exposure. Note: see McLeroy et al. for further information.](image-url)
life course. Children benefit when their caregivers see them as a unique individual with a balance of strengths and challenges and when caregivers are flexible in responding to a child’s unique developmental path. Clinicians can empower families with the knowledge that the caregiving environment, a modifiable factor, strongly influences a child’s development. At the community and society level, physicians can advocate for policies and services that may reduce PSE by supporting women of childbearing age to engage in treatment of substance misuse, increasing access to family planning resources, and improving access to treatment of psychiatric disorders and social support services to reduce isolation. Fighting against the stigma of substance abuse disorders is necessary for women to receive treatment and for babies to benefit. Clinicians, researchers, and families can move the field forward by calling for research that investigates the mechanisms and timing by which drugs of abuse alter brain development and study interventions for children affected by PSE.

To apply this discussion to the vignette at the outpatient pediatric clinic: the clinician can explain that the child may be at higher than typical risk of behavioral dysregulation; however, studies suggest that the independent emotional and behavioral effects of PSE may no longer be evident at 36 months. Her postnatal factors—including exposure to a caregiver with an active substance abuse disorder, possible developmental delays, recent caregiving disruption (from the likely primary attachment figure, the mother, and introduction to a relative stranger, father)—may be powerful contributors to her behavior, such as her dysregulated mood with her father, as observed in the outpatient pediatrics office. Long-term psychiatric effects of prenatal drug exposure can include problems in attention, behavior, language, and executive functioning. However, early intervention that includes medical and social services can be of great benefit and target parents’ drug use, improve parental functioning, and better the caregiving environment.25,26

### Take Home Summary

Use of illicit drugs during pregnancy carries significant stigma; however, many infants exposed to drugs of abuse prenatally have the potential to develop typically, and effects of the exposure may be ameliorated by environmental enrichment and quality caregiving.

### References


**About the Authors**

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**Disclosure:** Dr. Gleason has held stock in Merck but is now divested. Ms. Wagner reports no biomedical financial interests or potential conflicts of interest.

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The Boy Who Lived Well: Harry Potter as a Novel Tool for Teaching Cognitive-Behavioral Therapy Skills to Youth

Mark Sinyor, MD, MSc, FRCPC, Mark Fefergrad, MD, FRCPC, Amy H. Cheung, MD, MSc, FRCPC, Steven Selchen, MD, FRCPC, Ari Zaretsky, MD, FRCPC

After accidental injury, mental disorders including depression are the leading cause of disability globally in those aged 10-24 and the leading cause of death (by suicide) in high-income countries. In the United States, the yearly cost of treating depression has been estimated to be $23 billion, and that number doubles when costs associated with lost productivity are included.

Mental health literacy is considered a critical aspect for primary prevention of mental illness as it functions to increase awareness and recognition, decrease stigma, and encourage help-seeking. Cognitive-behavioral therapy (CBT) is an effective treatment for youth anxiety disorders, although it has not been shown to be more effective than other bona fide psychotherapies. These two approaches represent promising candidates for potential population-wide mental health interventions. Further, because psychoeducation is a core component of CBT, a CBT-based approach may be ideal for teaching mental health literacy.

School-based interventions for depression, often involving CBT or its elements, have been tested in several studies and often yield positive outcomes, although evidence is mixed as to whether teacher-led CBT interventions are beneficial. One limitation of existing school-based programs is that most have focused on interventions for secondary school students, with only a small number specifically targeting younger children prior to the typical onset of mood and anxiety disorders. Given the dearth of available evidence-based primary prevention strategies in mental health, even a small impact of universally acquired CBT skills could likely be highly meaningful and could likely substantially reduce disease burden as well as healthcare costs.

Harry Potter as a Teaching Tool for Mental Health Literacy

The 7-volume Harry Potter series has sold over 450 million copies, placing the series among the best-selling books of all time. In addition to being adored by readers worldwide, a number of mental health experts have written scholarly articles about these books, highlighting their value as a tool in psychotherapy as well as for mental health education. The novels have been identified as addressing central themes of adolescent development from a psychoanalytic framework, as well as addressing the major questions of Yalom's existential psychotherapy. The themes of bereavement in the series, most prominently Harry's loss of his own parents, have been highlighted for use with youth who are processing and grieving their own losses.

One of the major advantages of Harry Potter as a teaching tool is that readers are able to identify with the characters in the books and to ponder links with their own experiences including their relationships and emotional reactions. Perhaps most importantly, a key element of the books is Harry's remarkable resilience in the face of severe adversity, an outcome that has important implications for readers identifying with him since instilling hope may both protect youth from negative mental health outcomes and encourage help-seeking.

J.K. Rowling, the author of the Harry Potter series, has revealed to the popular press that she previously suffered from depression and was treated with CBT. Rowling has stated that the “dementor” characters that Harry first encounters in the third book in the series are patterned after her own experience of depression.
Despite the fact that the Harry Potter series was apparently informed by Rowling’s experience of CBT, no one has explicitly analyzed the books using a CBT framework. This is a missed opportunity in the literature as the books may present a ubiquitous, untapped resource for dissemination of basic CBT skills.

Our group has argued that CBT and other basic mental health skills ought to be incorporated into youth education as a primary prevention intervention. In this article, we present a framework for teaching basic CBT skills and mental health literacy to middle-school youth using the third book in the Harry Potter series.

Harry Potter and the Prisoner of Azkaban as a Tool for Teaching CBT Skills

Common elements of CBT include identifying thoughts, emotions, and behaviors, learning specific strategies to modify them (e.g. cognitive restructuring, exposure exercises, behavioral activation, problem solving), facilitating change through practice and homework, and relapse prevention. All of these elements are presented in a structured format following a typical sequence of CBT skill acquisition in Harry Potter and the Prisoner of Azkaban, the third book in the series. This will be summarized here according to topic and chapter(s).

Psychoeducation: Risk Factors for Depression (Chapters 1-4)

Chapters 1-4 provide a recap of the events of the first two books that functions as a synopsis of Harry Potter’s risk factors for experiencing depression (Table 1). The breadth and severity of these risk factors are notable since most youth will be able to find something with which they identify. These risk factors are also noteworthy because of the implicit message of hope

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>DETAILS</th>
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<tbody>
<tr>
<td>Early parental loss</td>
<td>■ Parents murdered when he was an infant</td>
</tr>
<tr>
<td>Abuse and neglect</td>
<td>■ Aunt and uncle fail to acknowledge him</td>
</tr>
<tr>
<td></td>
<td>■ Relocated to his room</td>
</tr>
<tr>
<td></td>
<td>■ Confined to a cupboard under the stairs in Harry Potter and the Sorcerer’s Stone</td>
</tr>
<tr>
<td>High “expressed emotion” environment</td>
<td>■ Yelled at, insulted, scapegoated by aunt, uncle, and cousin</td>
</tr>
<tr>
<td>Socioeconomic deprivation</td>
<td>■ Belongings locked up</td>
</tr>
<tr>
<td></td>
<td>■ Given a sock for his birthday</td>
</tr>
<tr>
<td>Limited peer support system</td>
<td>■ Not allowed to have friends growing up</td>
</tr>
<tr>
<td></td>
<td>■ Prevented from communicating by phone with his best friend Ron</td>
</tr>
<tr>
<td>Victimization/bullying</td>
<td>■ Multiple antagonists including his cousin (Dudley), school rival (Malfoy), and teacher (Snape)</td>
</tr>
<tr>
<td></td>
<td>■ Discrimination for minority status (targeted for being a wizard in the muggle world and for being the son of a muggle-born mother by some of his wizard peers)</td>
</tr>
<tr>
<td>Medical illness</td>
<td>■ Facial scarring</td>
</tr>
<tr>
<td></td>
<td>■ Repeated hospitalizations for injuries (see Harry Potter and the Sorcerer’s Stone and Harry Potter and the Chamber of Secrets)</td>
</tr>
<tr>
<td>Stressful life events</td>
<td>■ School problems (believes he is facing expulsion)</td>
</tr>
<tr>
<td></td>
<td>■ Criminal justice problems (believes he has violated laws for underage wizards)</td>
</tr>
<tr>
<td></td>
<td>■ Homelessness</td>
</tr>
<tr>
<td></td>
<td>■ Under physical threat (Voldemort, serial killer/Sirius Black)</td>
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</table>
presented throughout the book: that with the right tools, a person can overcome tremendous obstacles.

Psychoeducation About Depression (Chapter 5)
In chapter 5, Harry first encounters a dementor that, as mentioned above, is a proxy for the experience of depression. Table 2 presents both his experience of the dementor and his reaction afterwards. Harry’s initial response is to minimize the impact of the dementor and decline help. This functions as psychoeducation about help-seeking, a running theme in the novel; Harry invariably feels worse when he keeps his worries to himself and feels better when he shares them with trusted confidantes. In this chapter, he is also introduced to Professor Lupin, who can be thought of as Harry’s CBT therapist throughout the book.

Introduction to Cognitive Distortions (Chapter 6)
Here the reader is first introduced to Professor Trelawney, the divination teacher who is the embodiment of distorted and magical thinking. She predicts a negative future for Harry citing the “Grim,” a dog-shaped death omen. Her lesson on reading tea leaves illustrates common cognitive distortions such as catastrophizing, jumping to conclusions, and the fortune-telling error. This is in contrast to Harry’s subsequent interaction with his teacher Professor McGonagall and his friend Hermione, who are both paragons of rational thinking. Professor McGonagall encourages cognitive restructuring by highlighting the evidence that Professor Trelawney’s predictions never come true. Following this lesson, the book notes that “Harry felt better. It was harder to be scared of a lump of tea leaves away from… Professor Trelawney.”

Introduction to Fear Hierarchies, Behavioral Activation, and Core Beliefs (Chapters 7-8)
In chapter 7, Professor Lupin begins formal CBT training by introducing his class to the “boggart,” a creature that takes on the shape of the thing that the person encountering it most fears. He invites the class to practice neutralizing the boggart and, through the exercise, presents several key concepts of CBT, including that distress often takes a highly personal form but can have a similar impact on everyone, and that developing skills takes practice. The exercise ends with Lupin inadvertently triggering Harry’s negative core belief that he is incompetent by stopping him before he can take part. Harry assumes that this is because Lupin thinks he is weak and cannot succeed, when in fact Lupin is worried that the boggart will turn into Harry’s arch-nemesis, Lord Voldemort, and terrify the class. Chapter 8 provides powerful evidence to disconfirm Harry’s core belief of his own incompetence through the introduction of a fear hierarchy, behavioral activation, and explicit core belief work. Lupin continues his lessons by encouraging the students to gradually expose themselves to and master increasingly difficult magical creatures. Harry is encouraged to resume activities that give him a sense of pleasure and accomplishment, chiefly Quidditch, a sport at which he excels. Finally, Lupin meets with Harry, expresses his confidence in him, and provides evidence that Harry’s worries about the boggart were a cognitive distortion.

Table 2. Harry Potter’s Experience of the Dementor as a Metaphor for Depression

<table>
<thead>
<tr>
<th>REACTION DURING EXPOSURE</th>
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<tbody>
<tr>
<td>Perceives that time slows down</td>
</tr>
<tr>
<td>Feels like he will never be cheerful again</td>
</tr>
<tr>
<td>Experiences heightened awareness of his environment</td>
</tr>
<tr>
<td>Experiences confusion/a mysterious feeling that is experienced as intensely unpleasant</td>
</tr>
<tr>
<td>Experiences confusion/a mysterious feeling that is experienced as intensely unpleasant</td>
</tr>
<tr>
<td>Experiences physical sensations of intense cold, shortness of breath, drowning</td>
</tr>
<tr>
<td>Feels unable to move</td>
</tr>
<tr>
<td>Experiences painful recollections of past trauma</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>REACTION AFTER EXPOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorientation</td>
</tr>
<tr>
<td>Embarrassment, worries about what others think</td>
</tr>
<tr>
<td>Weakness, vulnerability</td>
</tr>
<tr>
<td>Worries about it happening again</td>
</tr>
<tr>
<td>Reluctance to seek help/go to the hospital wing</td>
</tr>
</tbody>
</table>
Setbacks (Chapters 9-11)

Problems and setbacks are aspects of CBT treatment that function as opportunities to re-evaluate and refine the treatment plan. In chapter 9, Harry again encounters a dementor and then loses at Quidditch for the first time in his life. He experiences grief, embarrassment, disrupted sleep, and a renewed reluctance to share his problems with others. He worries that the Grim will haunt him for the rest of his life. This depiction of his fear of relapse illustrates a common feature of early recovery from depression. Lupin continues cognitive restructuring work, targeting Harry’s feelings of shame.

Putting Skills Into Practice (Chapters 12-16)

In chapter 12, Lupin begins formal anti-dementor lessons with Harry. He warns Harry that this is a challenging task even for experienced adults and reassures him that he can overcome a dementor. This provides a parallel to the notion that just as many adults struggle with overcoming depression, youth can learn strategies to do so, as well. Harry begins tentatively, but sees early gains. With renewed confidence, he resumes his pleasurable activity, Quidditch, fends off bullies who have dressed as dementors to frighten him, and wins the match for his team. Shortly after that, during end-of-term exams, he receives full marks for dispatching a boggart and then actively challenges distorted thinking from Professor Trelawney, who presents him with a fortune-telling error during his oral exam.

Core Belief Work, Part II (Chapters 17-20)

By this stage, Harry has gathered enough evidence and done sufficient core belief work to have overcome his belief that he is incompetent. However, his second major negative core belief is addressed in chapters 17-20. Harry is an orphan who has been left with no meaningful connection to his parents. He believes that he is alone. Adding to this is his belief that his own godfather and parents’ former best friend, Sirius Black, is a serial killer who betrayed his parents and caused their deaths. In chapter 18, Harry has the chance to capture Sirius and turn him over to the dementors to be executed, but instead pauses to gather evidence and ultimately learns that Sirius is a good man who was framed and has actually been trying to help him. This demonstrates cognitive flexibility and openness to other ways of thinking, of which Harry was not capable at the beginning of the book. By being both flexible and open, he discovers that he has the love and support of his parents’ oldest friends, Sirius and Lupin, a powerful refutation of the notion that he is alone.

Consolidation and Relapse Prevention (Chapters 21-22)

CBT commonly terminates with a review of learning, reinforcement that patients now have many skills that they can draw upon if symptoms re-emerge, and planning for how they will respond to challenges after the therapy. In chapter 21, Harry and Hermione use a “time-turner” to go back in time with the knowledge that they have gained to create a different outcome in which Sirius’s life is saved. Harry neutralizes a large group of dementors and tells Hermione, “I knew I could do it this time…because I’d already done it. Does that make sense?” This underscores Harry’s new understanding that his CBT skills allow him to anticipate and master challenges. The book concludes with Lupin reaffirming Harry’s learning and noting that he is no longer needed, mirroring the CBT approach whereby patients are encouraged to view themselves as their own therapists.

Discussion and Next Steps

Based on the above, Harry Potter and the Prisoner of Azkaban is a promising and largely untapped resource for teaching CBT skills to youth. Potential advantages include that (a) as one of the best-selling novels of all time, copies of the book are ubiquitously available worldwide, meaning that it has the potential to be applicable and relevant across countries and school systems; (b) it communicates the core concepts of CBT elegantly in the context of a highly engaging narrative and; (c) it does so with characters to whom youth can relate. The Harry Potter novels are already in wide use in classrooms for the purpose of encouraging general literacy and there is a rich tradition of using novel study as a means of teaching youth about the world and about their own
life experiences. We propose that studies of the use of *Harry Potter and the Prisoner of Azkaban* should be undertaken in middle school classrooms to determine whether, as we anticipate, it is useful in advancing mental health literacy. School-based curricula could teach basic CBT principles as they relate to the book and encourage students to reflect on how the skills that Harry is learning could apply to themselves or their friends and family.

This approach would also require basic CBT education for teachers as well as support from local mental health resources should challenging questions arise or should students be identified as requiring mental health interventions. While we acknowledge, as described above, that evidence for universal, teacher-led mental health literacy programs is mixed at best, the potential use of Harry Potter for this purpose is sufficiently unique to merit consideration.

While the novel is well-suited to impart basic CBT skills in the classroom, it could also easily be adapted for use as a therapeutic aid in mental healthcare settings or in the home environment. Clinically, the novel could continue to function as a reference for patients and be paired with standard CBT exercises such as thought records and formal behavioral activation plans. Indeed, under ideal circumstances, youth patients presenting with mood and/or anxiety disorders would have already read the book in this context in school and would enter therapy already familiar with the concepts. This could facilitate both the efficiency and depth of CBT. At home, a parental guide could accompany the novel so that parents also learn some basic CBT skills and are supported in trying to have these conversations with their children in a supportive environment.

We acknowledge several limitations to this approach. First, since this is the third book in the series, reading the first two novels would be a prerequisite for an optimal understanding of the details and plot of the story. Second, for certain children, the written words in a chapter book may seem inaccessible and steps would need to be taken to facilitate other modes of learning such as having the book read aloud. Third, cultural sensitivity is an important consideration, and we don’t necessarily advocate for a global Harry Potter solution—in some areas, local traditions and stories may be much more pertinent. In this light, our Harry Potter approach is only one suggested template. Finally, while the cost of these books is modest and they are readily available at many public libraries, students and families struggling with poverty may have challenges procuring the text.

**Conclusion**

There is a demonstrated need for improved mental health literacy among youth, and *Harry Potter and the Prisoner of Azkaban* is a ubiquitous resource that can create a rich and accessible representation of CBT principles for young people. It has the potential to reach youth worldwide for this purpose. Whether its use will affect mental health literacy and outcomes has yet to be established empirically.

**Take Home Summary**

*Harry Potter and the Prisoner of Azkaban* is one of the best depictions of a youth learning cognitive-behavioral therapy skills in literature. The novel represents a potentially untapped resource for imparting CBT skills to youth in the classroom and beyond, which merits further attention.

**References**


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Ghous, genies, and other supernatural creatures often serve as a vehicle to take on the feelings an individual does not want to bear himself. These otherworldly beings can be the manifestations of suppressed rage, lust, greed, and other human emotions, and appear throughout art history. Henry Fuseli’s well-known painting “The Nightmare” features a glaring incubus atop the supine body of a woman, with a sightless horse standing behind. The painting transfixed and appalled London when it was exhibited in 1782, due in part to the undertones of sexuality—both of the unconscious woman and, according to contemporary hearsay, the artist. The incubus appears in other cultures, as well, including Muslim culture, where it is a type of jinn, or genie. These beings are believed to have their own free will and motivations and are associated with causing mental illness. This month, Rackley et al. consider the dynamics of interaction when religious beliefs meet secular psychiatric practice in the emergency department. Different religions explain mental health crises differently, of course, and this Clinical Perspective specifically concerns Islam (the Arabic words on the cover, transliterated, are hamazati-shayateen, or “the suggestions of the devils”). But, as the authors note, an approach founded on cultural competence—addressing language, cultural, and religious differences between the care team and the patient’s family—is invaluable to establish a strong working relationship between doctors and families of any background. That relationship in turn fortifies the patient’s psychiatric treatment, leading, ideally, to a better long-term outcome and keeping bugbears at bay.
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Cordelia Ross, MD, MS

Joined AACAP: September 2013
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Employer: Massachusetts General Hospital/McLean Hospital
CAP Interests: Transgender and gender-nonconforming youth, child abuse/neglect, and autism spectrum disorders

2014 AACAP Legislative Conference Travel Grant

Value: I had never considered myself an “advocate” before this experience. The conference gave me the practical tools and confidence to meet with legislators to voice my support for causes I believe in, most notably regarding children’s mental health. The most powerful and memorable aspect of this experience was listening to clinicians share compelling patient stories and to family advocates discuss their own lived experiences. The energy of the AACAP advocacy community is inspiring.

2014, 2015 Life Members Mentorship Grant for Medical Students

Value: I loved meeting and receiving wisdom from the Owls as well as the many other mentors at AACAP who are at different stages in their careers, including residents and fellows. I was provided with valuable guidance for applying to residencies and pursuing extracurricular activities in the field of Child and Adolescent Psychiatry. I was also grateful to connect with other trainees who share similar interests – they have since become good friends, co-residents and colleagues, and even co-collaborators on research and other projects.

For more information, visit: www.aacap.org/awards
The Tarasoff Duty to Warn in Child and Adolescent Psychiatry

Kim J. Masters, MD

Case: “John” is a 15-year-old male being evaluated for the first time by a child and adolescent psychiatrist for depression. During the clinical interview, John says that he has been thinking about killing himself with a rope or a rifle that he uses for target practice. His symptoms have become much more acute in the last week, when his 14-year-old girlfriend told him that she wanted to end their relationship. He says he cannot imagine living without her and is contemplating killing her as well as himself.

How should the clinician proceed? Two options are detailed below.

Background: The Tarasoff Decisions

The Tarasoff I and II v. Regents of the University of California decisions created a responsibility for clinicians to warn or protect potential victims of threats of violence by the clinicians’ patients. The case involved Prosenjit Poddar, who murdered Tatiana Tarasoff, a fellow student at University of California, Berkeley. He had met Ms. Tarasoff at folk dancing classes in the fall of 1968. She socialized with him there and kissed him. Mr. Poddar assumed these actions indicated that Ms. Tarasoff was interested in a relationship with him. When she rejected his advances and told him that she was involved with other men, he became depressed and angry. He went to the counseling center at the university for therapy. In a session with his counselor, Mr. Poddar expressed his intent to kill Ms. Tarasoff, who he felt had jilted him. However, Ms. Tarasoff was not informed of this threat because the director of the counseling center viewed disclosure to her as a violation of clinician–patient confidentiality.

Mr. Poddar again approached Ms. Tarasoff in October of 1969, and when she once again rejected his advances, he stabbed her to death. Subsequently, her parents sued the university. The case was reviewed twice by the California Supreme Court and was ultimately remanded for settlement.

Tarasoff I, the 1974 decision, established a clinician’s duty to warn potential victims, if patients communicated threats of harm to their clinician during treatment. With Justice Matthew Tobriner writing in summary for the majority, the Court stated:

We conclude that the public policy favoring protection of the confidential character of patient–psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.

This case was reviewed again in 1976. That decision, known as Tarasoff II, created a clinician’s “duty” to protect potential victims when threats of harm against them were expressed by patients during treatment. Since 1976 over 30 states have considered the limits of clinician–patient privilege, and over 20 have affirmed the Tarasoff decision either as a duty to warn or protect. Other states have either made the disclosure voluntary or found no clinician obligation to warn potential victims. In most states, the warning process is restricted to identified potential victims, but some states have established a duty to protect the public from a potentially violent patient even if unnamed. A website for individual states’ duty to warn or protect laws is available online. Mobley and Naughton and Applebaum and Gutheil have suggested that obligation to protect potential victims is an ethical obligation that overrides states’ legal determinations.
A Tarasoff I warning by a clinician to a potential victim and the police is an unusual activity for a mental health clinician, and in addition, it may disrupt the therapeutic relationship with the patient and the family. A complicating issue is determining what the warning would entail: for example, whether the clinician should disclose only that a threat had been made, or the specifics of the threat.

One way to try to prevent the rupture of the clinician–patient relationship is with pre-treatment consents, reviewed with patients and families, that define the limits of patient–therapist confidentiality in the event of threats of harm to others. Another is to apply protection strategies as an alternative to warnings. Overall, as Applebaum and Gutheil have noted, “Clinicians should choose the intervention that occasions the least disruption of the therapeutic relationship while still being effective. On some occasions hospitalization is appropriate; on others, police notification serves the purpose.”

Any youth who communicates threats to a clinician to harm another person needs to be assessed to determine the danger level of the threat. In substantial risk situations, the clinician needs to meet the Tarasoff warn or protect obligation requirements according to rules in that jurisdiction. It is important to understand facilities’ policies and local laws to help clarify how these situations should be handled.

### To Protect or to Warn?

#### Intent and Substantial Risk

Before embarking on a Tarasoff notification, it is important to consider when a duty to warn or protect obligation exists. In many states, Tarasoff statutes require that the patient has identified a victim by name, while in others, simply the threat of violence to others is sufficient grounds for a warn or protect action.

Determining the dangerousness of a homicidal threat can be informed by the concept of “substantial risk.” As Resnick has noted, the determination of substantial risk is based on the magnitude and probability of harm. A threat to kill with a butcher knife could be fatal and thus represents substantial risk to the victim’s life, even if it has a low likelihood of happening. On the other hand, a threat to slap a victim in the face would not have the potential to create a life-threatening situation, even if it had a high probability of occurring, and so would not be the type of situation for which the Tarasoff obligation was established.

#### Treatment Planning

Individuals who threaten harm to others typically need intensive treatment such as hospitalization because it provides both supervision and therapy. If the adolescent or the parent does not agree with the treatment plan, then it would be necessary for the clinician to forge a compromise that meets his or her responsibility to protect potential victims. If that cannot be achieved, then immediate warnings to the victims and the police may be necessary (see Table 1).

#### Table 1. Steps for Dealing With a Tarasoff Duty to Warn/Protect Situation

- Clarify the specifics of the threat
- Formulate an intervention
- Immediately remove weapons, especially firearms
- Review if possible with a consultant
- Present the intervention to the adolescent patient
- With the adolescent, present the situation and intervention to the parent
- Carry out the intervention; hospitalization preferred but warn if refused
- Address the underlying psychiatric issues
- Review the specifics of the threat during hospitalization
- Attempt resolution with the patient and the family and, if appropriate, intended victim and his/her family
- Review threat at discharge and in follow-up visits, employing an intervention when indicated
- Document all steps taken, including correspondence, in the medical record
Elements to include in the treatment plan are: inquiry about weapons, especially firearms and documented evidence of their immediate removal; psychiatric diagnoses; cultural attitudes; statement of the threat; results of rating scales; interventions to address patient and victim safety; family and patient input in treatment goals; planned therapeutic individual and family interventions; and documentation of response to interventions. A copy of the treatment plan should be provided to the patient and the parents.

Rating scales such as the Brief Rating of Aggression by Children and Adolescents (BRACHA), Structured Assessment for Violence in Youth (SAVRY), and the Modified Overt Aggression Scale provide state and trait information that may clarify patients’ states of mind, for example, whether threats of harm are part of a stable coping response to stress or are specific to the individual abandonment situation. However, these scales do not provide information about the implementation of threats. The Columbia Suicide Severity Scale, although not without clinical concerns, could be used to ask questions about both suicide and homicide intent. Asking youths about the likelihood of acting on the plan (intent) is important, because patients’ prediction of their own potential for violence has been shown to be a reliable indicator of future action.

**Cultural Considerations**

During adolescence, disruptions in romantic relationships (as in the original Tarasoff case) are a well-recognized stressor that may precipitate homicidal and suicidal planning. Cultures may view this situation and its resolution differently, depending on societal expectations. When an adolescent female makes threats entailing the use of violence, it can be occasioned by ongoing sexual abuse or a history of antisocial behavior. There has also been growing concern in the US, Japan, and the UK about the use of the internet, particularly among adolescents, to make murder–suicide pacts.

Firearms remain the most common method for both suicide and homicide events. Table 2 lists biologic, social, and history events that increase the potential for violence.

<table>
<thead>
<tr>
<th>Table 2. Historical Elements in the Psychiatric History that Help in Assessing the Likelihood of a Patient Carrying Out Threats to Harm Someone</th>
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<tbody>
<tr>
<td>- Self-harm, suicidal, assault, and homicidal ideation</td>
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<tr>
<td>- Self-harm, suicidal, assault, and homicidal plans</td>
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<tr>
<td>- Internet/social media communications about these issues including pacts for suicide</td>
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<tr>
<td>- History of both with emphasis on the most dangerous thoughts and actions</td>
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<tr>
<td>- Current and previous history of relationship initiation and ending</td>
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<tr>
<td>- Availability of weapons and specific plans to use them</td>
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<tr>
<td>- Current and previous history of substance use</td>
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<tr>
<td>- Adolescent patient’s assessment of likelihood of acting on these thoughts and plans</td>
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Seeking consultation from a colleague about the clinical situation and the planned intervention can be helpful because it provides an independent opinion on how to proceed.

**Possible Interventions**

A. Hospitalize the adolescent; have the weapons removed; do not provide victim warnings at this time. If at discharge the threat of harm is no longer present, there is no duty to warn. Document these actions in the medical record. If the intervention is successful and leads to the elimination of harm risk, this option has the advantage of allowing a therapeutic intervention with patients, their families, and, if appropriate, the potential victims and their families. It may be the choice that causes the least disruption in the treatment alliance. If the threat remains active at discharge, then the warnings can be delivered to the potential victim and the police.

B. Discuss the warning plan, including its content, with the facility’s legal counsel; as soon as possible, share this information with the patient and, if appropriate, the family. Warn the victim by phone and with regular and certified mail to increase the likelihood of delivery, and the police. Notification of both is necessary, because notification of the victim alone does not provide protection, and notification of the police alone does not ensure immediate action to protect
the intended victim. Document these actions in the medical record. This option is likely to disrupt the treatment alliance, and it also might make the patient less likely to share these issues with other clinicians (as may have happened in the Tarasoff case). However, warning may be the only workable choice.

Take Home Summary
The limits of clinician–patient confidentiality need to be discussed with patients and families at the initial visit. When youth threaten harm to others in treatment, weapons need to be immediately removed, and clinicians have a duty to protect potential victims, either by warnings or through intensive treatment, including hospitalization if necessary (Tarasoff obligation). All of these actions need to be documented in the medical record. The intervention should provide the least disruption to the therapeutic relationship that is effective.

References
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