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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. AAPAC 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.
With both its challenges and its celebrations, 2018 continues to fly by, and in its jet stream, I frequently have had to do balance checks. For me—particularly in the context of the illness that has befallen a close family member—"work-life balance" has been challenging. In speaking with colleagues, I simultaneously find comfort and discomfort in the recognition that I am far from alone. As a physician in academic medicine and particularly as a director of a residency training program, the phrase “work-life balance” has become omnipresent—especially in the context of initiatives focused on physician wellbeing. However, increasingly, I eschew the particular phrase “work-life balance,” given what I consider to be its direct and paradoxical threat to our wellbeing.

Firstly, the phrase artificially identifies “work” and “life” as two distinct entities. Last I checked, “work” is part of “life.” Others utilize instead the concepts of “professional” and “personal” instead, with which I also take issue; my identity as a professional is part of my identity as a person. I fully recognize the presumed intentions both of distinguishing one’s experiences at work from those outside of work and of increasing deliberate attention to both domains so that, in particular, one’s work domain does not subsume the other domain(s) in which each of us exists. If these, indeed, are the intentions, then I favor “work life” and “home life,” acknowledging the still-present shortcomings of these terms and recognizing that we likely exist in domains other than or in addition to these two.

Secondly, the “balance” of work-life balance positions the two entities (irrespective of the specific vernacular used) at opposite ends of a fragile seesaw. As such, “work-life” implicitly becomes “work vs. life.” The two inherently are at odds with one another and, thus, there indeed is a duel in this duality. If winds change and if one side of seesaw goes up, the other presumably must go down—at least for a period of time. While the opposition between these entities does underscore the idea that “something's gotta give” (which, in some ways, may be freeing), it simultaneously emphasizes the tension and rigidity of the implied system.

Finally, the “balance” of work-life balance further implies a forced singularity that is difficult, if not impossible, to achieve. It suggests that, of the infinite potential ratios between work and life, there exists only one at which balance can be attained. And, as if the task of identifying and landing on this single point were not challenging enough, the single point is a moving target. As circumstances in the various domains of our lives change, so does the positioning of the single point at which balance is feasible. I imagine the mounting frustration of a kitten trying to chase the tiny red dot of a frenetically motioned laser pointer; he can never catch and maintain that point.

Just as my active pursuit of work-life balance is a work-in-progress, so is my search for a phrase that more appropriately captures for me the goals and intentions behind the pursuit of work-life balance. For the time being, I’m settling for “work life-home life integration.” The word “integration,” including its associations with identity formation, seems to capture the possibility of many different facets of one’s personhood coming together in coexistence rather than in direct opposition. It also connotes a centeredness and a grounding that differs from the notion of tenuous balance. And “integration” feels more tenable, as less energy would be spent keeping work life and home life split off from one another and in balance/opposition with one another. “Integration” would better embrace infinite shades of ever-shifting grey.

This is a Spring/Summer double-issue of JAACAP Connect, and I apologize for the time that has passed between this issue and our last. As always, I am grateful for our authors’ contributions, and, with this issue, I also
am grateful for their patience. For this issue’s installment of the Lab to Smartphone column, Rettew walks us through the arguments of those who deny the existence of psychiatric diagnoses so that we may regard their arguments as understandable—not excusable—and rededicate ourselves to correcting the misinformation about psychiatry and psychiatric diagnoses that permeates the media. Upadhyay (page 11) presents a case and a review of anti-NMDA receptor encephalitis, a disease for which the median age of onset is skewed towards adolescents and young adults. D’Amelio and Glowinski (page 15) present graphic novels as an underutilized adjunct when teaching narrative medicine and psychiatric illness to trainees in their pre-clinical years. Kessler (page 20) encourages mental health professionals to consider the liberation psychology of Ignacio Martín-Baró, a Jesuit social psychologist, and to use its premises to identify and transform social structures that cause or perpetuate psychosocial trauma. Finally, Thordarson, Paternostro, and Friedberg (page 25) suggest that we integrate into traditional Cognitive Behavioral Therapy with young patients various popular culture icons who frequently are presented as flawed, who struggle, and who persevere.

Oliver M. Stroeh, MD
Editor

Call for Review Papers
Journal of the American Academy of Child and Adolescent Psychiatry

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AACAP AWARD SPOTLIGHT:
George ‘Bud’ Vana, MD

AACAP ADVOCACY DAY TRAVEL SCHOLARSHIP (formerly Advocacy Day)

AACAP’s Legislative Conference is where I got my start, learning how AACAP works and how to get more involved in the organization. I also found excellent mentors there and learned many strategies for how to communicate our patients’ stories. The conference is an opportunity to think about and advocate for the macro issues which affect children’s mental health and child psychiatrists’ practice. AACAP and Regional Organizations support medical students, adult psychiatry residents and child psychiatry fellows in attending Legislative Conference. During the two-day event, the Government Relations team and Advocacy Committee teach attendees how to speak to legislative staff and how to advocate most effectively for our patients’ mental health. I worked as a US Senate page in high school and got to watch the legislative process unfold. It has been great to come back to Washington, DC and to be able to talk about important issues with many of those legislators with whom I worked as a page. We see so much in the news about the dysfunction in Congress lately; it feels important to put a human touch on issues like CHIP funding, loan repayment programs for child psychiatrists, and support for early childhood programs. It is reassuring that there are also legislative staffers who are really passionate about these issues, too. Legislative Conference is a place where I feel like I get energized – thinking broadly about how to help all children then motivates me to do all I can to help my individual patients.

2013 AACAP LIFE MEMBERS MENTORSHIP GRANTS FOR MEDICAL STUDENTS, SUPPORTED BY AACAP’S LIFE MEMBERS FUND

While the Legislative Conference was the bait to get me involved into more AACAP activities, the Life Members Award, Life Member Programming and Life Members Dinner was the trap which has kept me all this time. Meeting the Life Members and learning about their paths through child psychiatry and illustrious careers, I was inspired and that inspiration continues. It was at a Life Member Program that I learned the history of the Triple Board (combined training in General Pediatrics, Adult Psychiatry, and Child Psychiatry) - something which helped solidify my interest and commitment to becoming a Triple Boarder.
Responding to the Psychiatric Diagnosis Deniers

David C. Rettew, MD

Another day, another book or blog post that boldly proclaims attention-deficit/hyperactivity disorder (ADHD) or some other psychiatric disorder really doesn’t “exist” and is instead a conspiracy of the pharmaceutical industry or an excuse people use to justify underachievement. To child and adolescent psychiatrists, these old accusations are pesky annoyances. But to our patients, these kinds of statements can really hurt, as they send the very clear message to them and everyone around them that there is no actual reason for their suffering and they should get themselves back on track immediately without any additional fuss. This is how stigma is generated and maintained, leading people to feel ashamed of their struggles and to avoid seeking help from anyone until the situation becomes dire.

In recognition of how destructive such cycles can be, we psychiatrists need to step up our game by engaging and refuting myths like this, both on the 1:1 level with our patients and families and to the greater public at large. Doing so effectively requires we first examine the “psychiatric disorders do not exist” argument with regards to its origins and logic to see how it stacks up, especially in comparison to non-psychiatric medical conditions.

In trying to do this, I had to admit to myself there might actually be good reasons why the public would have trouble accepting psychiatric disorders as bona fide medical entities. The diagnosis of hypertension, for example, flows rather simply from a simple objective number that doesn’t rely on patients trying to describe their inner feelings or doctors having to interpret what the word “often” or “significant” means within a DSM criterion. Pneumonia can be seen on an X-ray and comes from some actual foreign organism that isn’t supposed to be there, in comparison to some of our own psychiatric conditions, like generalized anxiety disorder, which isn’t readily observable even on our best neuroimaging technology. Now that sounds suspiciously like feelings all of us have at least once in a while.

A little understanding, however, of emerging research coupled with closer inspection of the ways many non-psychiatric medical disorders exist reveal truths that can help us make sense of these apparent discrepancies. Add in a small dose of humility and honest self-reflection, and we are almost there in figuring out why so many people erroneously deny the existence of things we deal with every day.

The first insight is that psychiatric disorders, at least on the phenotypic level, are largely dimensional constructs. While the DSM system continues to require a yes/no approach to psychiatric disorders, it is becoming overwhelmingly clear from science that very little in our field actually exists this way.1 Anxiety magnitudes, attention span, activity levels, and autistic spectrum symptoms are all complex dimensional entities that lack clear boundaries between normal and abnormal. So how then does one draw the line between a trait and a symptom? In my training, I was taught that the trait/symptom conundrum could be solved with a single word—namely, impairment. Unfortunately, it turns out that impairment is pretty dimensional too. That leaves us with having to create some kind of arbitrary “speed limit” between what is and isn’t a disorder, with plenty of grey area in between where different people might legitimately disagree. It’s similar to the height that a person would need to achieve before being considered “tall.” Few people argue over the person who is 6 foot 6 or 4 foot 6, but what about the guy who is 5 foot 10?
Making matters even more complicated is the emerging literature that this dimensionality likely extends beyond the level of the phenotype into neurobiology as well, which may help partially explain why the search has been so elusive to find the lab test, the cause, or the brain abnormality underlying pretty much all of the common conditions that psychiatrists treat. In other words, it’s looking like all the complex interacting genetic and environmental factors that contribute to a child being a little hyperactive are the same ones that get turned up to make other kids a little more hyperactive. This then implies that neuroscience may not help us as much as we’d like to “carve at the joints” with regard to the boundary between typical and atypical.

These aspects of psychiatric disorders need to be appreciated, but they certainly don’t undermine the legitimacy of psychiatric disorders as brain-based entities. Neuroimaging and genetic studies consistently find evidence of neurobiological differences between patients and controls—it’s just that these differences tend to be quantitative rather than qualitative, and that’s okay. Look a little deeper at some of the most common non-psychiatric illnesses such as hypertension, high cholesterol, or type 2 diabetes, and we also see dimensionality. Experts often tinker with their cut-offs as to what should constitute a disease just like we do, just without all the critics. Sure, it would be simpler if we could just point to something on an X-ray or MRI, but those who are ready to declare anything they can’t see on an image or lab report as nonexistent will need to write off everything from severe autism to most complaints of physical pain. If you are feeling a headache about now, that will probably have to go into the world of make-believe, too.

Furthermore, it’s not just psychiatric conditions that can have multiple causes or, using the more technical term, show equifinality. Turning back to hypertension, it is important to remember that the most common version of hypertension is actually “primary” or “essential” hypertension, which means that there isn’t some specific cause we can point to as the culprit. Sound familiar?

The second important point to understand about the psychiatric disorder deniers is that this issue is really about medications. If the treatment for serious psychopathology was a warm bath and a good night sleep, nobody would really care about this issue. However, to a big swath of the American public, a formal diagnosis of a psychiatric condition equates to a firm recommendation for a psychiatric medication. In my view, we need to own up to the fact that there is some truth to this stereotype. Furthermore, what is most troubling to many is the frequency with which medications are being given not as a treatment for a patient’s emotional-behavioral struggles, but as the treatment. Combine this trend with the reality that there has been a fairly precipitous drop over the past several decades regarding the official threshold for how severe behaviors need to be before they qualify as pathological, and the ground becomes fertile for skepticism.

Of course, making any kind of defense problematic, is the inconvenient truth that too many physicians continue to be overly cozy with the pharmaceutical industry. Having just endured a bruising public policy debate in which I tried, mainly in vain, to explain that marijuana is not a harmless cure-all for every mental and physical malady out there, I can sadly report to you that the continued schmoozing between practicing physicians and the pharmaceutical industry has seriously eroded our credibility as honest brokers of scientific information. It turns out that it doesn’t matter at all that I receive nothing from drug companies and haven’t written an opiate prescription in over 15 years. I was still perceived as another corrupted soldier deployed by the opiate manufacturers to squelch the right of 80-year-old grandmothers to have their pain properly treated. In the starkest of terms, I finally understood that the excessive ties between physicians and pharmaceutical companies hurt the integrity of all physicians, not just the ones accepting the gifts and money.

Seen in this light, the current backlash against psychiatrists and the diagnoses that we make may not be excusable, but it is a heck of a lot more understandable. By fully being able to appreciate the complexity and dimensionality of psychiatric disorders, we can more effec-
tively communicate to our patients and to the public at large why we might not actually expect our diagnoses to light up easily on a quick lab test or imaging scan. By acknowledging that our field still has work to do to reduce our reliance on medications and the companies that make those medications (and even better by taking steps to accomplish this reduction), we can regain the level of respect and trust so many dedicated and hard-working child and adolescent psychiatrists deserve when we try to deliver our rebuttals to the vast quantity of misinformation about psychiatry and psychiatric disorders that currently permeates the media.

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.

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.
AACAP’s Douglas B. Hansen, MD, 44th Annual Review Course emphasizes the most recent material relevant to the general practice of child and adolescent psychiatry and serves as an up-to-date review of child and adolescent psychiatry as well as addresses important clinical research. The course is designed to update practitioners on state-of-the-art standards of diagnosis and treatment.

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AACAP’s Legislative Conference and Assembly Meeting

May 2 - 3, 2019

AACAP’s 2019 Legislative Conference and Assembly Meeting will take place in Washington, DC, from May 2 -3, 2019. Join us for both events to advocate for children’s mental health.

**AACAP Legislative Conference**

On May 2 - 3, AACAP’s Government Affairs team will teach you about the legislative process, provide you with advocacy materials to help you develop and deliver the most impactful messages, and schedule your meetings with legislators on Capitol Hill. Join us as we advocate for children’s mental health, and make your voice heard!

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

**AACAP Assembly Meeting**

On May 4, AACAP’s Assembly of Regional Organizations will meet to discuss the issues facing your state and region. The Assembly consists of AACAP member representatives from across the nation and is always looking for more voices and advocates like you to join the discussion.

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.
Anti-NMDA Receptor Encephalitis: Diagnosis Delayed Is Almost Treatment Denied

Anu Upadhyay, MD

M. is a 17-year-old Asian-Indian young woman with no prior psychiatric or medical history. She was in her usual state of health until she began experiencing difficulties with memory, attention, concentration, and erratic sleep patterns. D.M. described herself to her parents as "Not myself...everything is bad...I am going down." Alarmed, D.M.’s parents brought her to an emergency department (ED) to be evaluated. She was assessed and medically cleared the same day and returned home with a plan to follow up with her primary physician.

Two days later, D.M. had her first witnessed seizure. In the ED, D.M.’s neurological exam, comprehensive metabolic profile, serum magnesium and phosphorous levels, urine analysis, and urine drug screen were all clinically unremarkable. The white blood cell count was slightly elevated at 14.3 (4.5-13.0 thousand micro-liter [mcL]). Given the largely unremarkable medical work-up, she again was discharged home that day. Three days later, D.M. had yet another witnessed seizure at home and returned to the ED. An electroencephalogram revealed mild diffuse slowing, which is suggestive of cerebral dysfunction. D.M. was prescribed levetiracetam for seizure prophylaxis and was discharged home. Later that same day, while speaking with her parents, D.M. demonstrated frank thought disorganization and reported that she was experiencing thoughts to cut herself. Her parents brought her back to the ED, and D.M. was medically cleared and transferred to an inpatient psychiatric facility for stabilization and treatment, given concerns for suicidal ideation.

At the psychiatric facility, D.M. was reportedly mute, isolative, unfocussed, refused to eat, exhibited sleep disturbance with frequent waking, and demonstrated ongoing thought disorganization in addition to emerging behavioral disorganization. During this psychiatric hospitalization, D.M.’s parents refused any standing medications.

Due to concern for an underlying medical condition as the potential cause of D.M.’s psychiatric symptomatology and clinical presentation, D.M. was transferred back to the ED and admitted to the neurology inpatient service, where she underwent further diagnostic medical work-up. Her differential included nonspecific functional neurologic symptom disorder or questionable infectious etiology or adjustment disorder, and D.M. was discharged home.

Four days after D.M.’s discharge, the results of both her serum anti-N-methyl-D-aspartate (NMDA) receptor antibody titers and cerebrospinal fluid (CSF) anti-NMDA receptor antibody titers returned elevated (1:40 and 1:1, respectively). D.M.’s parents were called to have D.M. medically readmitted due to concerns of anti-NMDA receptor encephalitis. After readmission, an MRI of the pelvis with and without contrast showed a right adnexal teratoma. Meanwhile, she was treated with intravenous immunoglobulin (IVIg) for 2 days, intravenous steroids for 5 days, and this was followed by a 6-week oral steroid taper. This regimen improved her confused mental status and rigidity. She was continued on 500mg of levetiracetam orally in the morning and 1000mg orally at night for seizure prophylaxes, with no further seizure activity. Finally, she received gynecologic oncology treatment for a tumor resection.

Anti-NMDA Receptor Encephalitis

Introduction, Presentation, and Differential Diagnosis

Anti-NMDA receptor (anti-NMDAR) encephalitis is an acute form of encephalitis that is potentially lethal, but has a high probability for recovery. Most patients with anti-NMDAR encephalitis develop a progressive,
multistage illness that can involve an initial prodrome, the emergence of neuropsychiatric symptoms, and the development of critical medical instability. Potential symptoms include anxiety, social withdrawal, mania, psychosis, impaired cognition, memory deficits, seizures, dyskinesia, catatonia, loss of consciousness, hemiparesis, cerebellar ataxia, and autonomic dysfunction. Distinguishable from primary psychiatric illnesses, a characteristic of anti-NMDAR encephalitis is that a majority of patients experience at least four symptoms over the course of the disease, with many patients experiencing six or seven. Behavior changes are less likely to be the first symptoms in children as compared to adults. While there is a broad range of severity of these symptoms, new and increasingly severe symptoms typically emerge and rapidly progress over a five-to-fifteen-day period.

When considering a diagnosis of anti-NMDAR encephalitis, other infectious, metabolic, and toxic causes should be considered. Serotonin syndrome and neuroleptic malignant syndrome can also have similar presentations, and should be high in the differential. Though less likely than the above mentioned disorders, one should still include in the differential, degenerative diseases, autoimmune causes of primary vasculitis, systemic autoimmune diseases, and steroid-responsive encephalopathy associated with autoimmune thyroiditis.

Incidence
The overall incidence of anti-NMDAR encephalitis is unknown, but we do know that 81% of reported cases have occurred in female patients and that there seems to be a higher frequency of the illness in Asian and African populations. Furthermore, anti-NMDAR encephalitis is increasingly recognized in adolescents and young adults. Over a third of reported cases have occurred in children, and only 5% of reported cases are over the age of 45. Disease onset is skewed towards adolescents and young adults, with a median age of diagnosis of 21 years.

Possible Pathophysiology
The exact pathophysiology of anti-NMDAR encephalitis is still unknown, but several theories exist. The reasons why NMDA receptor antibodies are produced in humans are unclear. The association between anti-NMDAR encephalitis and ovarian teratomas may exist as a result of the NMDA receptor-containing neural tissue frequently present in ovarian teratomas (which often contain many different cell types), suggesting that anti-NMDAR encephalitis may be a paraneoplastic syndrome. It is presumed that teratomas might elicit an immune response, resulting in the production of antibodies. In general, patients with an underlying tumor develop more robust immune responses than those without a tumor. The antibodies produced to target NMDA receptors in the teratoma then are thought to develop cross-reactivity for the NMDA receptors in the brain, perhaps reflecting a breakdown in immunological tolerance. This potential mechanism, however, does not account for the presence of anti-NMDAR encephalitis in individuals without any identified neoplasms.

Another theory regarding the etiology of anti-NMDAR encephalitis suggests that infection may trigger immune system activation that then shifts to an autoimmune response, resulting in the production of anti-NMDA receptor antibodies. The fact that anti-NMDAR antibodies consistently are found at greater concentrations in the serum than in the CSF (on average, 10-fold higher) strongly suggests that the antibody production is systemic rather than localized to either the brain or CSF.

A pathogenic role of the anti-NMDAR antibodies is suggested by the correlation between antibody titers and neurological outcome, and by the decrease in the number of postsynaptic clusters of NMDA receptors caused by the antibodies. Several NMDA-receptor antagonists, such as dizocilpine (MK801), ketamine, and phencyclidine, cause psychosis and autonomic dysfunction similar to those observed in anti-NMDAR encephalitis, suggesting that a reduction in NMDA receptor function due to the antibody-mediated reduction in number of NMDA receptors may be a contributor to the pathophysiology of anti-NMDAR encephalitis. Of note, a characteristic feature of patients who recover from anti-NMDAR encephalitis is a persisting amnesia, which would be consistent with a reduction in NMDA receptor function, given the NMDA receptors’ key role in learning and memory and associated mechanisms of synaptic plasticity.
Treatment
Anti-NMDAR encephalitis is a potentially treatable disorder and has a better prognosis with early identification. About 77% of patients with anti-NMDAR encephalitis initially seek the help of a psychiatrist, so this diagnosis needs to be included in the differential diagnosis of patients presenting with acute onset of psychiatric symptoms, perhaps accompanied by seizures or movement disorders.

Aggressive treatment and a multi-disciplinary approach is vital for this complex syndrome. Initial therapy includes high-dose steroids, IVIg, plasma exchange, and removal of any causative neoplasm, if present. During the acute phase, most patients require care in an intensive care unit to stabilize breathing, heart rate, and blood pressure. In approximately 75% of patients, manifestations resolve with treatment. Long-term outcomes show that 79% have a recovery to near-baseline functioning in 24-month, 6% die, and the rest are left with mild to severe deficits. Recovery is slow and may take 3 or more years, or those affected may not regain their premorbid level of health. A possible explanation for the slow recovery could be the inability of most commonly used treatments to lead to rapid and sustained control of the immune response. Once improvement is noted, most patients continue to improve over weeks or months until fully recovered. As a result of general deconditioning and occasional spinal cord involvement, patients often need prolonged physical therapy. Relapses in children may be multiple and occur in 20-25% of cases, so ongoing monitoring and screening for at least 2 years is recommended.

Conclusion
Anti-NMDAR encephalitis is a relatively new diagnostic entity which represents a new category of immune-mediated disorder that is potentially lethal, but usually reversible if promptly recognized. Since most patients with neuropsychiatric symptoms present for psychiatric care in the initial period, it is important for psychiatrists to be familiar with this condition, diagnose it, and collaborate treatment with multi-specialty teams for a better overall prognosis. It will be of future interest to research and assess further the potential role of various psychotropic medications as well as electroconvulsive therapy in lessening the psychiatric symptom burden associated with anti-NMDAR encephalitis.

Take Home Summary
D.M.’s initial presentations without neurologic symptoms or past history of encephalitis suggests that some cases of anti-NMDAR encephalitis can be mistaken for a primary psychiatric disorder. Since no specific treatment guidelines exist, psychiatric treatment is based on clinical experience and anecdotal evidence.

References
About the Author

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

Child Separations and Toxic Stress Statement and Article Collection

In support of an official statement from the editors, the Journal of the American Academy of Child & Adolescent Psychiatry offers an article collection including:

- Mental health in Syrian refugee children resettling in the United States: war trauma, migration, and the role of parental stress
- Childhood trauma and illicit drug use in adolescence
- Traumatic stress interacts with bipolar disorder genetic risk to increase risk for suicide attempts
- Trauma exposure and externalizing disorders in adolescents

View The Statement and Full Collection - jaacap.org/toxicstress
Students enter medical school looking forward to finally working with and helping others. However, for many students, the lived experiences of patients continue to remain out of reach. Psychiatry is a medical field that quintessentially emphasizes listening and trying to understand the stories of patients, but typically, students get little exposure to this before entering their clinical years. Instead, lists of *DSM* criteria, drug mechanisms and frequent or serious side effects are memorized. The only real psychiatric clinical exposure may be in the context of learning how to conduct the patient interview and, on occasion, involve a patient interviewed in front of the class. A psychiatrist interviewing a patient who is manic often demonstrates how to identify or elicit symptoms of pressured speech or grandiosity, but less frequently demonstrates for students how one can explore the ways in which the patient’s life is impacted by illness. Given the constraints of the preclinical classroom, other mediums may be useful in providing in-depth, personalized examples of illness experience, such as narrative medicine.

Narrative medicine uses the ability to recognize, interpret, and respond to stories to enhance the practice of medicine by applying the humanities to gain a better understanding of the human experience of disease. Rita Charon explains that there is a story, not just symptoms, behind every person who sees a clinician. The goal of teaching and learning narrative medicine is to produce a clinician who listens to a patient’s story and does not just excise pertinent positive and negative symptoms but also examines how illness is affecting an individual’s health, well-being, and psychosocial functioning. Successful use of the principles of narrative medicine is characterized by empathic listening, honest communication, validation, and frequent reflection skills. By understanding illnesses as stories, clinicians gain the tools required to extract clinical evidence from the patient narrative while also establishing rapport through empathy and respect. A small qualitative study of fourth-year medical students found that students perceived narrative medicine practices as improving their communication and increasing empathy. Another study looked at the effect of a narrative focus on the education of psychiatry residents. In this study, residents were expected to review *DSM* criteria prior to class and spent the class applying the diagnostic framework to narratives of patient experiences with specific mental illnesses. The small case study found that residents felt strongly positive subjective responses towards the exercises and showed statistically significant improvement in pre- and post-intervention test scores when asked to list diagnostic criteria present in narratives.

Literature provides an important avenue to uniquely experience the narratives of patients with psychiatric illness. Books such as *An Unquiet Mind* or *The Center Cannot Hold*, relay the real-life experiences of patients with bipolar disorder and schizophrenia, respectively, and the effects these illnesses have on these patients’ personal, interpersonal, and professional lives. In Elyn Saks’ *The Center Cannot Hold*, Saks narrates an episode in which she initially is studying for a law assignment and ends up venturing out onto the roof of the school library. The flow of thought and emotional transitions that Saks describes provide for the reader an inside view of the thought disorder she experienced as part of schizophrenia. Her descriptions of the delusion she experienced—that she was responsible for many deaths—educate the reader to the certainty and terror with which some people experience delusions. After investigating these literary accounts of mental illness, one wonders which other mediums can express the real-life experience of severe mental illness. A somewhat surprising answer can be found in graphic novels.
Graphic novels, compared to more traditional methods of narration, provide readers unique opportunities to gain insight into the experience of illness. The visual components of graphic novels allow the author to bring his or her experiences to life on the page through both depiction and description, perhaps leading to a more complete representation. The graphic novel *Marbles: Mania, Depression, Michelangelo, and Me: A Graphic Memoir* is an account of the author's first-hand experience with bipolar disorder, including mania, depression, medication side effects, and interactions with family and care providers. The graphic novel includes a two-page spread that perfectly exemplifies the concept of flight of ideas. The difference between logical thought, tangential thought, and flight of ideas can be difficult to grasp, and educators may resort to invented visual aids. In this particular spread in *Marbles*, the reader sees the original single idea experienced by the author, but, tracing the thought bubble across two pages, bears witness to the process by which the idea multiplies and spreads to a variety of different thoughts, some related and some completely unrelated to the initial idea. The reader simultaneously can follow and “understand” the evolution of each individual thought, but, stepping back and observing the spread as a whole, can experience first-hand overwhelming confusion, chaos, and entropy emanating from the page, making it easier to appreciate the author's experience and what was going on in her brain.

The joint presentation of drawings and accompany narrative inherent to the comic format can help the reader better understand and empathize with the patient's experience of illness in a way that written language, alone, may not. In a section in *Marbles*, the author puts together nine frames, each exemplifying her experience of a drug combination she used at one time or another. In contrast to passively reading a long list of possible side effects, the more active visualization of the experience of side effects presented in parallel with the patient's general state of mind helps the reader identify with the person and his or her experience. The ability in a graphic novel to place different images in the same field of vision also allows for direct comparisons of experiences. Another graphic novel, *My Friend Dahmer*, depicts the childhood and teenage years of the serial killer, Jeffrey Dahmer, from the perspective of his friend and classmate. In this book, Dahmer is shown simultaneously both as the aloof, reserved person seen in interviews he did as an adult and as an awkward, spasmodic teenager mimicking a family friend's cerebral palsy. Often, providers only get to see one perspective—a particular patient, in a particular setting (eg, an outpatient office), at a particular point in time. However, this utilization of the graphic novel medium reminds us of the multiple facets of our patients, including their many characteristics, dimensions, and ways of expressing themselves in different settings. In *Stitches*, a graphic novel recounting the experience of a child suffering from chronic illness and struggling with difficult family dynamics, the reader witnesses a child seeing his psychiatrist not as a doctor, but as the rabbit from *Alice in Wonderland* and the only individual to tell the boy the truth. The images relay emotions such as fear, worry, despair, and elation in a manner that more immediately is accessible to the reader—in a way, bypassing the reader’s need for words and inducing experientially an implicit, empathic response.

An advantage derived from the graphic novel's use of images and the framing of these images is the opportunity for the reader to witness the interaction between the individuals portrayed. In *Marbles*, the author continually returns to the depiction of sitting in her psychiatrist's office and discussing her symptoms. Throughout the story, the reader can witness fluctuations in the patient's state, from her initial choice of aggressive clothing, to her depressed tearfulness and apathy, to finally, her gradual acceptance and realization of steps she must take to optimize living with her illness. Throughout these experiences, the reader also sees the psychiatrist tempering grandiose expectations, preparing the author for relapses, and providing education. The use and overlay of speech or thought bubbles, combined with the organization of image framing, allow for a palpable understanding of the interaction occurring in the protagonist's thoughts—in some cases, crowding out the psychiatrist and her advice and, in others, bringing the psychiatrist's statements and their impact to the forefront. This also is seen in *My Friend Dahmer*, where the reader gains a level of compassion for Dahmer that otherwise might
be almost impossible to experience given his violent actions. Throughout the story, the reader sees Dahmer as somebody who is not developing along with his peers. Whereas the other characters can be seen investing in their personal, social, and future lives by developing hobbies, applying to and preparing to leave for college, and beginning romantic relationships, Dahmer’s character continues to remain arrested in his development. He repeats those behaviors that had gained him some popularity when he was younger, even when those social behaviors no longer have any currency or capital. As Dahmer loses his social traction, he is included in fewer and fewer frames. In this way, readers can experience the slow change in the relationship between Dahmer and his peers, and his struggles to maintain his social position.

There is a growing interest in the use of narratives in medical education to promote better understanding of the patient experience while building the skills necessary to extract clinically-relevant information from patient histories. This includes insights into how a person’s life is affected by fear, disease symptoms, medication side effects, and the complicated medical system that the patient tries to navigate. The unique ability of the graphic novel medium to visually portray complex processes allows a trainee to better understand difficult-to-relay emotions and experiences, and to see multiple co-existing viewpoints. Examining patient narratives through multiple mediums during early training would allow for larger schematic organization as students begin to see their first patients. Students assigned to read graphic novel narratives would reinforce not only basic preclinical concepts, but also their understanding of and empathy for the human experience of illness. Given the specific strengths of the comic format, graphic novels are an overlooked option and a neglected adjunct when teaching narrative medicine and psychiatric illness to trainees in their pre-clinical years.

**Take Home Summary**

Preclinical medical students have limited exposure to psychiatric illness. Growing evidence suggests there are benefits to approaching medicine from a narrative perspective. Graphic novels represent an alternative method of presenting psychiatric illness to students that has unique strengths.

**References**


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Jeffrey R. Strawn, MD

“2009 AACAP Pilot Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows

Project Title: Neurophysiology and neurochemistry of generalized anxiety disorder in adolescents

2012 AACAP Pilot Research Award for Attention Disorders, supported by the Elaine Schlosser Lewis Fund

Project Title: The neurophysiologic impact of anxiety on attentional processing in adolescents with ADHD

These awards allowed me to embark on projects related to the neurophysiology, neurochemistry and neuroanatomy of anxiety disorders in children and adolescents. Funding from these AACAP Pilot Awards supported our examinations of cortical thickness, gray matter volumes and functional activity in anxious adolescents. This work revealed abnormal cortical thickness in an ensemble of regions responsible for fear learning, fear extinction, reflective functioning (e.g., mentalization), and regulation of the amygdala. We also observed that glutamate in the anterior cingulate cortex is directly linked with anxiety severity in youth. Taken together, this body of work propelled additional studies—with great collaborators—that focus on these structures in youth who are at risk for developing anxiety disorders and studies that integrate treatment and neuroimaging in anxious youth. Additionally, data generated from these AACAP awards provided a scaffold for work that disentangled the neurophysiologic impact of co-occurring conditions on the neurocircuitry of anxiety disorders. In this regard, we have examined the impact of co-occurring anxiety in youth with major depressive disorder on gray matter volumes. Our findings suggested that gray matter deficits in specific regions in youth with anxious depression compared to patients with major depressive disorder and no anxiety may reflect the more severe psychopathology in these patients. Finally, based on the early support from these AACAP awards, we are now examining several important psychological factors including attachment style and reflective functioning with regard to specific neurostructural and neurofunctional fingerprints in anxious youth that may have implications for psychotherapeutic treatment in these patients.”

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JOINED AACAP: FEBRUARY 2008

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2014, 2015, 2018 SUMMER MEDICAL STUDENT FELLOWSHIP MENTOR”
Liberation Psychology as a Resource for Child Psychiatrists

Carol L. Kessler, MD, MDiv

I first encountered Ignacio Martín-Baró’s liberation psychology when I volunteered for the Salvadoran Archdiocese Health Project in 1987. At the time, physicians working with the poor in El Salvador were persecuted. Aesculapius International Medicine, a small non-profit organization, responded to the Salvadoran Archdiocese’s request for health professionals who would be less likely targets of dollar-backed bullets. We would travel to towns in conflict zones to teach volunteers to diagnose and treat the most common diseases. Poor survivors in remote areas became health promoters for their neighbors. Seeds of liberation were sown.

Martín-Baró’s work continues to sustain me in my work as a community psychiatrist in the Bronx, New York. Since he wrote in Spanish, his work before he died was barely known beyond Latin America. After he, his five Jesuit university professor colleagues, their housekeeper, and her daughter were dragged into a university garden and shot in the head on November 16, 1989 by the US-trained Atlacatl Battalian, members of the Committee for Health Rights in Central America translated some of Martín-Baró’s works so they could be available beyond Latin America. His colleagues created the Ignacio Martín-Baró Fund, which has supported hundreds of community mental health projects in marginalized communities throughout the world (www.martinbarofund.org). With this paper, I offer liberation psychology as a resource for child psychiatrists.

Liberation psychiatry affirms the role of mental health professionals in identifying oppressive structures in our communities so that we might advocate for their transformation. In my Bronx context, it has inspired me to not only care for children affected by disproportionate minority confinement but to partner with the Osborne Association (www.osborneny.org) to advocate for children of incarcerated parents. It affirmed my work with AACAP’s Juvenile Justice Task Force that ultimately led to my co-editing the book, Mental Health Needs of Young Offenders. It inspires me not only to diagnose and treat children affected by threats of parental deportation, but to participate in Physicians for Human Rights’ Asylum Network, wherein the voice of children and families fleeing persecution might be heard. It leads me to not only detect disorders affecting academic functioning, but to educate parents about their children’s educational rights. Liberation psychology invites all mental health professionals to root ourselves in our particular context, to detect structures that systematically inflict psychic harm, and to join in efforts for social transformation in the service of mental health.

A Psychology of Liberation

Ignacio Martín-Baró PhD, a Spanish-born, University of Chicago-educated, Jesuit social psychologist, was the vice rector of the Central American University in El Salvador during its protracted civil war. The tools he learned abroad left him helpless as he witnessed unspeakable horror. And so, Martín-Baró fashioned new tools that would bear witness to and support the spark of life and hope for liberation in the face of brutal oppression. Though these tools are relevant to an assessment of structural issues in all communities, they are still little-known outside of the Latin American context where they were born.

Martín-Baró’s liberation psychology was deeply influenced by the liberation theology flourishing amongst marginalized communities at that time. African American, Asian, and Latin American theologians shed the notion of theology as reflection on a universal God. Instead, they saw God present in marginalized communities’ struggles for justice and peace. They spoke of God’s “preferential option for the poor.” They noted that the Bible tells of a
God who parted the Red Sea to liberate the people of Israel from Egyptian bondage. In the Christian tradition, they reminded the poor that Jesus walked among them while he confronted oppressive structures. They affirmed that poverty was not an individual flaw, but the product of structural sin that perpetuates injustice.

Similarly, Martín-Baró focused not on an individual's diagnosis but on the psychosocial trauma resulting from civil war. For El Salvador, war between a military-backed democracy and the Frente Farabundo Martí para la Liberación Nacional (FMLN) guerillas would last from 1980 to 1992. By the end of the war, 75,000 civilians had died, more than one million had been displaced, and among the disappeared, an estimated 3,000 were children. The science of psychology had been used to inflict psychological, “low intensity” warfare that had high intensity effects: torture without visible scars, and propaganda targeting the hearts and minds of the people. All Salvadorans’ abilities to make sense of their reality were threatened by what Martín-Baró would call a “limit situation” – one that could destroy or spark inner resources to imagine a better tomorrow.

Martín-Baró was ultimately killed by the war he described as a structure built upon violence, social polarization, and lies. The creed of violence declared “might makes right.” Reason was used to devise military operations instead of fostering debate between conflicting social groups. As aggression replaced words, the roots of social relationships were critically damaged. Martín-Baró feared that many came to believe the solution for violence was violence itself.

Martín-Baró also stated that, with protracted civil war, the social fabric was disected into factions: us versus them; democracy versus communism; and soldier versus guerilla. This polarization led to dehumanization of the other and created a “crack in the foundation of co-existence.” Individuals lived in a context that pressured allegiance to one side or another. Many tried to remain “neutral,” to dissociate themselves in an effort to survive.

The third facet of war was the institutionalized lie. Propaganda espoused images and a narrative that distorted reality. Contradicting the official story would place one at risk of being labelled subversive. As a result, many silenced their opinions and feelings or made vague utterances about “the situation.”

Martín-Baró sought to combat psychosocial trauma by identifying war’s toxic structure. He allied with those within and outside El Salvador who sought an end to war through peaceful negotiations. He created public opinion polls as a safe space for Salvadorans to give voice to their thoughts and perceptions. He was inspired by those Salvadorans who never ceased to believe that a just future was possible.

Relevance of Liberation Psychology for Child Psychiatry

Martín-Baró’s liberation psychology can serve as a resource for community psychiatrists who diagnose and treat individuals and families in the context of structures that inflict psychic harm: lack of access to health care and quality education; substandard housing; endemic community violence; lack of access to safe space for play; multigenerational poverty; and disproportionate minority confinement. We see children in families disrupted by incarceration, foster care, deportation, and untreated parental mental illness.

Psychiatrists witness the effects of structural violence in clinical encounters. We may feel helpless, overwhelmed, or, in the spirit of Martín-Baró, see ourselves as agents of structural transformation. AACAP was instrumental in advocating for the end of death sentences for crimes committed as a juvenile through dissemination of knowledge about adolescent brain development. AACAP also cites evidence of the harm inflicted by parent-child separation as it takes a stance against zero tolerance immigration policies. Child psychiatrists have the opportunity to increase chances for individuals to be granted refugee status through the Physicians for Human Rights’ Asylum Network. (www.phr.org). We can support medical students who are creating such asylum clinics as The Weill Cornell Center for Human Rights. We can educate parents about their educational, housing, and immigrant rights. We can inform them of recreational opportunities and scholarships. We can link them to legal resources.
Aware of the risks, Martín-Baró chose to remain in El Salvador, as he became inspired by the resilience and tenacity of those committed to heal a broken social fabric. He was inspired by the psychiatrist Viktor Frankl, who not only survived the concentration camps of the Holocaust but created a new form of healing—logotherapy—that placed the search for meaning at the center of mental health. Martin-Baró found meaning in the development of liberation psychology that would identify the roots of psychosocial trauma, so that they might be transformed. Liberation psychology invites child psychiatrists to work with one another, with our patients, and with other professionals to mend our social fabric in the service of mental health.

Take Home Summary
In the context of El Salvador’s civil war, the Jesuit social psychologist, Ignacio Martín-Baró, created a liberation psychology that can serve as a resource for community psychiatrists everywhere. It encourages mental health professionals to identify social structures that inflict psychosocial trauma and to work toward transforming these structures in the service of mental health.

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Carol L. Kessler, MD, MDiv, works as a community child psychiatrist with Astor Services for Children and Families in the Bronx, NY, and is an ordained pastor in the Evangelical Lutheran Church in America, Chicago, IL. Since 1987, when Dr. Kessler first volunteered in El Salvador during its twelve-year civil war, Dr. Kessler has worked with the Central American community in New York and as a voluntary consultant to mental health programs in El Salvador and in Mexico. She has documented her work in a chapter of the book, Disaster Psychiatry: Intervening when Nightmares Come True. She has been on the faculties of the Albert Einstein College of Medicine, Icahn School of Medicine at Mount Sinai, and Columbia University Vagelos College of Physicians and Surgeons.

Disclosure: Dr. Carol L. Kessler reports no biomedical financial interests or potential conflicts of interest.
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Integrating Pop Culture Icons Into CBT With Young Patients

Micaela A. Thordarson, PhD, Jennifer K. Paternostro, PhD, Robert D. Friedberg, PhD, ABPP

Bruce Wayne/Batman: I wanted to save Gotham. I failed.

Alfred Pennyworth: Why do we fall sir? So that we can learn to pick ourselves up.

Batman Begins (2005)

Self-doubt is an equal opportunity emotional villain. In Christopher Nolan’s Dark Knight trilogy, Batman/Bruce Wayne is portrayed as a vulnerable individual combatting multiple adversities. The dialogue above between Bruce Wayne/Batman and his trusted butler Alfred, illustrates the universality of self-doubt, as well as the power of persistence and resilience. Failure is inevitable and cannot be absolutely avoided, but it also provides us with lessons for how to rise up after life’s hard knocks strike us down. Popular culture heroes such as Dory from Finding Nemo, characters like Riley from Inside Out, and Batman all model endurance in the face of distress. They all keep calm and carry on!

Coping skills training is fundamental to Cognitive Behavioral Therapy (CBT). Finding creative ways to teach these skills via covert modeling and metaphors is a nice augmentation to the traditional approach. Covert modeling takes place in the mind’s eye, so imagination is critical. Children envision a valued person dealing with some hardship and then mentally picture themselves imitating the model’s coping behavior. The best type of covert model is one who is flawed and struggles but perseveres in managing mishaps. Batman, Riley, and Dory are prime examples of coping models, and the lessons they teach young patients are described below.

Inside Out: Riley, Emotional Awareness, and Acceptance Save the Day!

Taking place in the mind of an eleven-year-old girl named Riley, Pixar’s Inside Out provides a vivid portrayal of the way emotions serve survival functions. Throughout the movie, the Feelings, adapted as their own characters of Joy, Sadness, Fear, Anger, and Disgust, struggle to support Riley in coping with moving to a new city. The Feelings all work in the Headquarters Control Console to help Riley emotionally navigate the rough waters associated with relocation.

Integrating the lessons taught by Inside Out with CBT concepts is an extremely easy task. One of the foundational skills of CBT with youth is providing psychoeducation. Joy, Sadness and the rest of the Feelings personify different moods through prototypical situations. Utilizing movie clips, clinicians can demonstrate to young patients how to recognize and label their thoughts and emotions. For example, the scene where Riley is walking into her new school for the first time is an excellent depiction of a common stressor. All of the Feelings weigh in on the experience. Fear predicts catastrophe, Disgust reacts to the “cool girls,” Sadness sparks homesickness, and Joy tries to modulate and put a positive spin on things. Once a child is familiar with spotting the stressor, clinicians can direct attention to emotions, invite young patients to draw their own Fear or Disgust characters, and then place the emotion in their “headquarters.” Furthermore, Inside Out communicates that all emotions are acceptable, cognitive structuring modulates aversive states, and facing distress is preferable to avoiding it.

Riley’s memories are often reframed throughout the movie, teaching young patients that events are interpreted in many different ways and are associated with the dominant emotions. For example, during a hockey game, Sadness remembers that Riley missed the winning goal and the team lost the championship game. Yet, when Joy is activated, Riley reframes the event by remembering the support and love she
felt from her family and teammates. Through these examples, *Inside Out* fuels the application of cognitive restructuring concepts.

**The Dark Knight Helps Us Rise and Build the Will to Act**

Batman is an especially fitting superhero because he is so imperfectly human. His identity is forged in tragedy, and trauma is burned into his neural connections. Randall M. Jensen wrote:

> Origin stories are typically driven by incredible and fantastic events: genetic mutations, strange laboratory accidents, alien encounters, dealings with the devil and so on. But Batman's beginnings are different! The crucial catalyst—an alleyway mugging gone bad—is all too ordinary.  

Because Batman is so completely human, he must rely on his knowledge, flexibility, resourcefulness, and relationships to handle misfortune. Batman's humanity makes him a strong covert coping model, and his tools are proper metaphors for coping skills training.

For instance, let’s take the case of nine-year-old Edgar, who exhibited externalizing behaviors, relying on tantrumming, yelling, and other disruptive behaviors to attract his parents’ attention. He believed that people should never feel frustrated or see themselves as thwarted. For him, these feelings were beyond the realm of “human” experiences. Coping with these unpleasant thoughts and feelings was an overwhelming task requiring extraordinary skills. Fortunately, he was a huge Batman fan, so making the link to a human superhero seemed like a natural strategy. The therapist and Edgar discussed Batman's adversities, frustrations, anger, and failures, as well as the way he humanly coped with them. Subsequently, the therapist and Edgar made a stencil cut-out of the Bat signal and placed it over the lens of a flashlight. Together, they practiced shining the Bat signal whenever he wanted his parents’ attention instead of engaging in his previously maladaptive behavior.

While many superheroes have special tools such as a lasso (Wonder Woman), hammer (Thor), shield (Captain America), and ring (Green Hornet), Batman's utility belt is filled with manufactured gadgets that are not supernatural in power and are used by a distinct human being. Consequently, we think Batman's utility belt is also an apt metaphor for cognitive behavioral coping skills training. Using this utility belt metaphor in practice can be seen with the example of Micah, a 10-year-old boy who was diagnosed with persistent depression. He saw himself as “low down,” “a loser,” and “lame.” He was the target of verbal teasing by peers and commonly internalized these insults. He felt helpless and unable to cope with distress and difficulties. The therapist knew Micah idolized Batman and then elected to use the utility belt as a metaphor. Over the course of treatment, Micah and his therapist built a number of coping strategies (eg, self-instruction, problem-solving, reattribution, and problem-solving) and organized them into various compartments in his “coping utility belt” according to the different situations where the skills were needed (eg, home, gym class, lunch, bus). Batman helped Micah rise!

Batman represents a coping model who is able to face distress and endure despite adversities, making him a fitting model for practicing exposure. In *Batman Begins*, a major theme is developing *the will to act*. Willingness is essential when coaching children through exposure treatment. In fact, employing a scene from *Batman Begins* to teach exposure to young patients in individual and group work is a favorite strategy. Bruce Wayne returns to the scene of an earlier trauma where he was terrified of bats. He willingly embraces being surrounded by these flying creatures, tolerating and eventually welcoming the experience. Patients identify with Batman and learn that even superheroes experience anxiety and that facing fear is a bold tactic.
Finding Nemo: Just Keep Swimming!

Dory: Hey, Mr. Grumpy Gills. When life gets you down do you wanna know what you’ve gotta do?

Marlin: No, I don’t wanna know.


Another popular character that brings CBT interventions to life is the blue tang fish, Dory, who captured viewers’ hearts in Finding Nemo. Dory’s optimistic, determined, and hopeful attitude help push her forward despite major obstacles. Dory is not perfect—her struggles with memory significantly interfere with her ability to maintain friendships and lead a “normal” life. Despite this deficit, Dory commits herself to her pursuits and accomplishes goals that seemed initially impossible. This is an important lesson for youth who feel helpless, demonstrate distorted negative thinking, or are pained by their imperfections. When mired in depression, anxiety, or bombarded by psychosocial stressors, it is easy to feel defeated and lose motivation. Incorporating Dory into treatment as a covert model inspires young patients to persist in the face of adversity.

Finding Nemo offers various metaphors for teaching young patients about self-instruction. During her various adventures and misadventures, Dory did not reach her goal in one step. Rather, her experiences were a series of hits and misses that built a path towards success. Further, Dory is best known for her personal motto: “Just keep swimming!” which enabled her to persist despite adversities. Her catchphrase is well-suited for teaching cognitive coping skills to distressed youngsters. Clinical experience indicates that young patients seem to love to chant this statement! In addition to motivating young patients to endure and carry on, this declaration generates positive affect and hopefulness. Constructing coping thoughts can also be accomplished by writing or drawing coping cards that say “What would Dory do?” In this way, patients come to view their life experience as an expedition.

Dory is an apt model for social skills training. She rarely keeps friends for long and is repeatedly building new relationships. By playing brief video clips of Dory as she interacts with new characters, clinicians are able to break down social skills into discrete, simple elements that are easily understood by young patients. Additionally, many young patients are hesitant to rely on others, believing they must manage things alone; others do not understand how to determine the right time to seek support. Using Dory’s friends as examples, clinicians are able to help youth identify who in their lives is Marlin (a best friend), Crush (an expert), Hank (someone needing help in return), and Destiny (a specialist). Young patients quickly grasp these concepts and the roles people in their lives play.

Conclusion

In conclusion, integrating popular culture icons into traditional CBT with young patients is strongly recommended. Pop culture characters are engaging and fun! We strongly recommend integrating popular culture icons into traditional CBT with young patients. Nevertheless, the research cupboard evaluating the approach’s efficacy and effectiveness is relatively bare. Certainly, basic efficacy studies examining traditional CBT procedures compared to pop-culture augmented CBT is necessary. Further, interesting and clinical findings have historically guided basic efficacy research. Ideally, this will be the case with CBT and pop culture icons. Until then, CBT oriented clinicians are urged to carefully experiment with the use of popular culture metaphors making sure they are relevant to young patients’ experiences and sociocultural contexts.

Take Home Summary

CBT with young patients can be challenging and integrating popular culture icons into the treatment approach can be helpful. Using characters from Inside Out, Batman, and Finding Nemo may engage young patients in psychoeducation, cognitive restructuring, and exposure procedures.
Integrating Pop Culture Icons

References

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