LifeMember
OWL NEWSLETTER

Fall Edition 2025 e-Newsletter

Welcome to the Fall Edition of the Owl News!

American Academy of Child & Adolescent Psychiatry
www.aacap.org

Quotes About the Fall Season

"Autumn... the year's last, loveliest smile."

— **William Cullen Bryant**

"I'm so glad I live in a world where there are Octobers."

— **L.M. Montgomery**

"Life starts all over again when it gets crisp in the fall."

— **F. Scott Fitzgerald**

"Every leaf speaks bliss to me, fluttering from the autumn tree."

— **Emily Brontë**

"Autumn is the second spring when every leaf is a flower"

— **Albert Camus**

COMMITTEE

GET INVOLVED! SUBMIT ARTICLES FOR THE OWL NEWSLETTER!

We want to hear from you! Let us know what you are up to, how you're doing, and more! Please send materials to communications@aacap.org

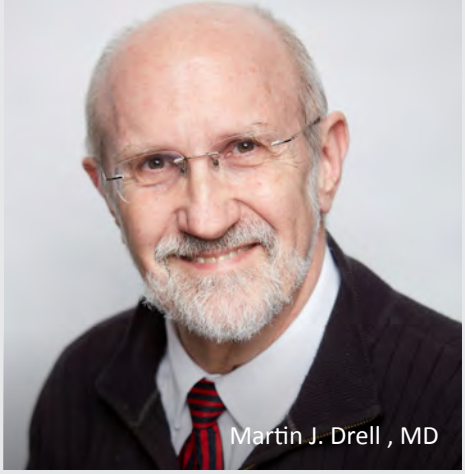
IN THIS ISSUE

COVER ART:

Golden leaves frame a watchful owl, its yellow eyes bright in the soft light of autumn. Owls feel like the season itself, you know, quiet, wise, and present as the days grow shorter. Based on the white-spotted crown, dark facial border, and small size, it's likely a Boreal Owl A fitting emblem for fall's calm and clarity.

Bourgeois Expansionistic Forces

By Martin Drell, MD


Martin J. Drell , MD

Since the beginning of my career, I have had a love-hate relationship with making diagnoses. I believe they are necessary but prone to abuse. They are both overused and underused, leading to tragic results in many cases. I much prefer formulations that better categorize the people 1 see and attempt to assist.

My feelings were reinforced (in the early 80's) when I did a literature review on trauma and PTSD. The eview pointed to what appeared to me a repetitive cycle in which the concept (currently called PTSD) became popular then became overextended and then evolved over time. The cycles seemed to begin with traumatic events that led to new names for the syndrome. These events were most often wars. It seemed to start with a disorder named "railroad spine" after many serious injuries secondary to the massive growth of railways in the mid-1800s. Other teams over the years included: "soldiers' heart", shell shock; war, battle fatigue, combat stress reaction (CSR) before the Vietnam war spawned the currently used PTSD. Each cycle seemed to focus on etiology being either physical, usually at a level that could not be defined by the science of the day, or psychological. Each cycle also led to a general fascination with stress and trauma with an expansion of the concept and its diagnosis. To me, stress and trauma began to explain and pathologize too many of the conditions that people must deal with in life. It seemed at this point that it explained so much that it collapsed under its own weight. I remember clearly articles that indicated that a large percentage of medical interns suffered from PTSD as did a good percentage of mothers of children having undergone tonsillectomies. I wondered at the time if things were diagnostically out of control.

After Hurricane Katrina there seemed to be another repetition of the cycle. There was surely major suffering. I did not question that the traumatized were in dire need of care. I was concerned about whether they all had PTSD or complex PTSD and worried that being given the diagnosis had its own consequences.

Truth be told, my concerns did not keep me from further expanding the concept to include very young children who I felt had PTSD after I treated several young children with dog bites and other traumas. I expanded it even further by following the diction of Winnicott that one cannot conceptualize young children without considering their caregivers and hypothesized a phenomenon called "PTSD a deux" after noting that the caregivers often had PTSD like symptoms. Whatever I saw seemed a "transactional" issue involving more than just infant!

My quandaries have continued to fascinate and perplex me with each new iteration of DSM. I am still pondering the massive expansion in bipolar diagnoses in pre-pubertal children and the "spectrumization" of autistic disorder. Do we really need more diagnoses? Is this not expanding the numbers of people who have mental health disorders? Doesn't this lead to even more stigmatization?

Being psychodynamic, I prefer to focus on one patient at a time. As mentioned

earlier I prefer a good developmental, systems based, biopsychosocial formulation to a good diagnosis especially when diagnoses tended to be linked to what I believe to be non-comprehensive treatments that involved only medications that are certainly helpful but often do not deal with the totality of the problems involved.

As my concerns with bipolar disorder and autistic spectrum disorder lessen, I am now faced with the expansion of anxiety and its diagnoses. I see family after family that are confronted with a tsunami of anxiety who respond by assisting themselves and their children in ways that promote avoidance and a worsening of the anxiety. Doing the logical seems to lead to helicoptering and doing things for their children and others that they should do themselves, thus leading to a lack of resilience and further increases in anxiety. Avoidance certainly works in the short term but has long term consequences that were most surely amplified by covid that continues to cause stress and trauma.

This brings me back to where I began this column. Bourgeois expansionistic forces. How can we tie all these phenomena together?

As someone who tends to be much better at identifying issues than solving them, I depend on the kindness of those smarter and more articulate than I at organizing my concerns for me. Such a person is Nick Haslam, PhD who in 2016 wrote a wonderful article on "Concept Creep" and a follow-up article in 2021 on "Concept Creep and Psychiatrization." They articulatea hypothesis on processes that underlie my decades of concerns over what I termed "bourgeois expansionistic forces."

'Concept Creep,' according to Haslam refers to the gradual semantic expansion of harm related concepts such as bullying, mental disorder, violence, prejudice, stress and trauma to include topics which would have not originally been envisioned to be included under that label (Wikipedia).

In essence the "meaning" of the concepts are broadening. As an example, he notes that traumahas gone from physical injuries to psychological worries. Likewise, bullying started with a special focus on peer aggression and power plays has now expanded to adults with new categories such as cyberbullying. Haslam comments that such expansions occur horizontally by including newer related phenomena and vertically by including phenomena with less impact. This process, which has been amplified by ever expanding social media has led to widening ideas of what is horizontal and vertical with subsequent widening concerns for "social justice."

In his 2021 article, he focuses on the concept of concept creep to the field of psychiatry and psychiatric diagnoses. He posits that "Concept Creep" has led overtime to a widening of what is described as pathological and worthy of diagnosis. He contends that this has led to more people being diagnosed with disorders as well as more people believing that they have disorders. He speaks to the impact of social media on self-diagnoses with all the consequences that such may entail.

As I read the article I thought of the impact of diagnoses and misdiagnoses over the short and long term as people develop and mature. I especially worry about the impact of diagnoses on the identity formation of youth.

I will now use the term "concept creep" in the place of "bourgeois expansionistic forces." I urge you to take a look at Haslam's work and see if it is relevant to your professional lives. I will leave my thoughts on how well "Culture Creep" explains other phenomena in the larger world than psychiatry for another column. ■

1. Manvir Singh- Read the Label: How Psychiatric Diagnoses Create Identities. The New Yorker 5/13/2024. P 20-24
2. Paige Lay le, But Everyone Feels This Way: How an Autism Diagnosis Saved my Life (2024). Hachett Go, Paris.
3. Nick Haslam, Jesse S.Y. Tse, Simon De Deyne. Concept Creep and Psychiatrization. Front. Social. 16 December 2021
4. Haslam N., Dakin B.C., Fabiano, F, McGrath, F, Rhee, M.J., Vylomova, Fetal (2020) Harim Inflation: Making Sense of Concept Creep. Eur rev. Soc. Psycho! 31 (1) 254-286
5. Haslam, N. (2016) Concept Creep: Psychology's Expanding Concepts ofHarim and Pathology. Psycho!. Inq. 27, 1-17.
6. Haslam, N., McGrath, M. (2020) The Concept Creep of Trauma. Soc. Res. 87, 509-531
7. Frances, A. (2013) Saving Normal: An Insider's Revolt against Out-of-control Psychiatric Diagnosis. DSM-5, Big Pharma, and the Medicalization of the ordinary. William Morrow Greg Lukianoff, Jonathan Haidt: The Coddling of the American Mind. (2018) Penguin Books

Difficult Destinations: A Co-Chairs View

By Ellen Sholevar, MD

Ellen Sholevar, MD

Having just returned from an inspiring and stimulating two-week trip to Mongolia and Türkiye, learning about events of the 13th century and before, the inherent challenges of understanding the genius of Genghis Khan, the impact of the Mongols on the world order, stretches the mind and provides perspective. Genghis Khan, 1162-1217, conquered a vast area stretching from the Pacific Ocean to Europe and he and his descendants had a profound impact on the "flourishing of arts, development of skilled crafts, and the progress of research in botany, medicine, astronomy, measurement systems, and historiography." "Ceramics, manuscripts, textiles, music, poetry, weapons" were highly valued. The level of brutality and cruelty in establishing this empire is also difficult to understand and put in perspective in past world history. *And what are the implications for our current age?*
A fellow traveler on this journey described a trip to a country characterized as a "difficult destination," one that had little provision for tourists, was demanding physically, and presenting many challenges. How does one prepare for and meet the challenge of such a destination? At this point, our field of child and adolescent psychiatry may be one of those "difficult destinations." We are faced with decreased resources for children and adolescents, evaluating and treating children and adolescents, with the tools we have at hand, yet knowing that societal factors have tremendous impact over which we have no control. How do we continue with hope and energy in the face of challenging times?

We must look at the charge of our Life Members Committee to work together and continue to commit to the values we hold dear. A review of the charge of our committee:

- Reach out to and communicate with Life Members to stay engaged with AACAP in a variety of ways including a regular Owl newsletter.
- Promote, solicit donations for, and award medical student and resident travel grants.
- Create and submit the Call for Papers the Life Members Wisdom Clinical Perspectives.
- Sponsor and promote the Life members Luncheon at the Annual Meeting.
- Serve as mentors for AACAP members, especially medical students, and residents.

We look forward to sharing our commitment to fostering the welfare of children and adolescents and working together to achieve our goals. We appreciate your continued support and engagement. ■

AACAP 2025 OCT 20–25 Chicago

American Academy of Child & Adolescent Psychiatry
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Hyatt Regency Chicago and Swissôtel Chicago

Life Members Luncheon

11:30 AM to 1:00 PM

Celebrate the heart of our community. Join fellow Life Members for a warm, lively lunch where you'll reconnect with longtime colleagues and welcome our award winners as they launch their careers in child and adolescent psychiatry. Share your wisdom, swap stories, and help shape the next generation of leaders.

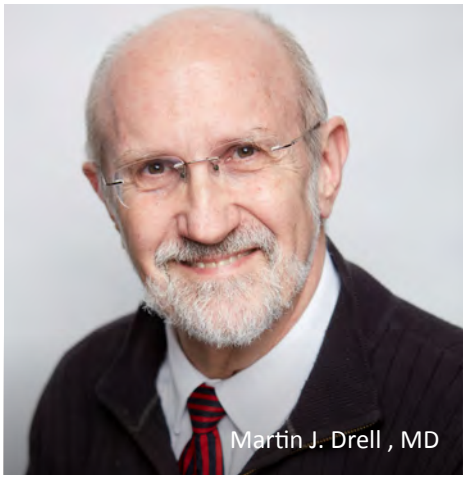
Tickets are required and available through meeting registration. Seating is limited, so reserve early.

Questions? Contact the Registrar's Office at registrar@aacap.org or 202.966.7300, ext. 2005.

WE LOOK FORWARD TO SEEING YOU IN CHICAGO!

Clinical Vignette: "The Play's the Thing, wherein I'll Catch the Attention of the King… of the Jungle"

By Martin Drell, MD



As many of you will remember, I used to have a regular column called "Clinical Vignettes" in AACAP NEWS. As editor of the Owl's Newsletter, I realized that I could contribute my clinical vignettes to the Owl News instead. I hope the Owls will enjoy my new vignettes and encourage them to submit their own vignettes for future issues.

One of my favorite activities when doing therapy

is when I see children with their parents and the children begin to play. At these moments I get the privilege of introducing the parents to the wonders of play. I begin by telling the parents about the normality of play as well as the fact that play can be valuable in gaining clues to what may be bothering children as well as how to treat them. It is my experience that this is news to most parents who generally pay little attention to their children's play.

I remember one young child with behavioral disorder who went straight to the playhouse and played out a boy having trouble sleeping because his parents were downstairs having a fight in which pots and pans were being thrown. As he focused on the play the parents were aghast.

"We thought he was asleep. We did not know he knew that he was having troubles." They asked their son about what he felt was going on. He straight forwardly told them he was worried that they were going to get a divorce like some of his friends and that he was afraid to talk with them for fear it might be true. After they explained that they were not planning to get a divorce, he was mightily relieved and calmed down in the session and at home. All left the session with agreater respect for play and play therapy.

Most cases are not so simple. In many ways it takes time to figure out what's going on. I consider "play" a therapeutic tool. I do not automatically use it on all young children. If young children can talk, I begin by talking. If that doesn't work, I often turn to play for potential hypotheses. Even then, the understanding of the play can take many sessions that can be hard to fathom.

My skills at playing and interpreting play can be useful outside the therapy office.

Recently, I used them with my son during our regular facetime visits. I suspected that his almost five-year-old son, Lou, was not pleased with my call as well as the strong suggestion from his father that he should talk to grampa. It is my general experience that any time a parent is on the phone with mom or dad, the kids magically start pestering. They wish to have the total attention of their parents. Such reactions often occur in older children and adults.

Lou attacked his father, David, with great ferocity, saying that he was the tiger and his dad the lion. "I'm going to scratch you with my claws." He said it over and over.

My son protested "Oh my God, why are you doing this to me?" Lou persisted: "I'm going to claw you. This then escalated to "I'll scratch your balls." My son who was part annoyed, and part humored repeated over and over "why are you doing this?" He spoke to me about why Lou didn't act this way with his mom." I answered, "because she isn't a lion and she doesn't have balls." My son, remarked, "what does that have to do with his behavior. He's crazy!" "No" I said, "He's just a normal feisty almost five-year-old playing a little tiger with his big powerful lion father. You know you are the King of the Jungle!"

I then asked Lou directly who would win in a real fight between a tiger and a lion. He immediately told me that the lion would definitely win. My son then asked me what to do when Lou persisted in such play. I normalized the play by pointing out that most mammals often play and have play fights. Some theorize that this is practice for potential real fights in the wider cold and cruel world. "When one of the dogs gets overly aggressive the other dogs usually intervene to get the "feisty" puppy to stop. I noted that play fights have their own rules. "If Lou gets out of control and starts to hurt you it is time to set boundaries." I then asked if Lou was actually hurting him. My son said that he really wasn't and let the play fighting continue. When Lou was getting more "revved up" I suggested that David set a boundary and suggested that he might intervene earlier in the future. I noted that Lou was indeed a feisty puppy who needed help identifying when he was being too frisky.

David was, by tradition, reluctant to set meaningful boundaries. He wasn't a big fan of "time outs" and would threaten them more often than carrying out his "threats." When he managed to set a time out, Lou stopped immediately and changed the play. His dad was now a veterinarian who would patch up Lou's fictious wounds that were inflicted during the play. Upon being bandaged, Lou switched to playing dominos in which the participants set up the dominos so that they can watch them sequentially fall down. This was a new more rule bound and scheduled game.

On future Facetime calls the Tiger and Lion game persisted with numerous permutations of the Tiger and Lion game in addition to the veterinarian game and the domino game.

During my next visit, I noted that the game of Tiger and Lion continued, but in a more playful manner with less aggressiveness. My son was now more educated and less irritated, which enhanced the chances for fun. Lou, in turn, was more in control. He no longer threatened to claw my son's balls.

In a latter visit to see them in California, my son was making meatballs and asked Lou to help. He lovingly agreed. As they made the meatballs, Lou observed his dad intently and modelled his actions. He held his hands in the same way. As they continued Lou's smaller hands made little meatballs. My son suggested how Lou could make bigger balls. Lou did so and smiled with pride. His balls were as big as my dad's! As this occurred, I used another play therapy strategy (called the "sports caster" strategy) in which I played an "impartial" observer describing the action as it unfolded in great detail. I made sure to try and add feelings to my broadcasts and ask questions without necessarily expecting answers. By doing so I hoped to let David and Lou know what was going on in their father and son play. At dinner I applauded the two chefs. Who would have thought that the King of the Jungle and the Frisky tiger could make such wonderful food!

Follow-up:

On subsequent calls I asked for updates on the Tiger and Lion game. In response I was told that Lou had morphed the tiger into a "mutant" tiger with Dad becoming a "human" that was not allowed to fight back. After several more weeks, I was told that Lou had added new tiger and lion powers. The tiger now had the power of camouflage so that he could not be seen. The lion, in turn, was given an even "mightier" roar that was guaranteed to frighten away the tiger even when the camouflage made him invisible. I was told that the new powers of the lion were strictly rationed. He was only allowed to use the mightier roar three times.

On a subsequent visit to California, which was about a year after I had been first told about the Lions and Tigers game, I was told that the game was being played less often. Lou now prefers to ask Dad instead to practice soccer with him. Nothing like kicking the balls around.

While writing this vignette, I remembered that David's favorite "stuffy" which he gave to the frisky, now six-year-old, Lou was Rory the Tiger that was given to him by my wife's father. Grandpa Lou had two daughters and no sons. He adored David and David adored him back. When Grandpa died David and his wife chose to name their son after his Grandpa Lou. I call him "Big Lou!" ■

The Pitt: A Day in the Life of an ER

By Peter R. Cohen, MD and Alina Mitchell, MD

This column focuses on how movies and TV shows can enhance our clinical perspectives as we tend to the stresses and hopes of patients and families from different cultures and countries. These productions can also prompt and amplify clinical discussions between psychiatrists and those they train, supervise or mentor.

First, a note about how this critique of "The Pitt" came about:

At a Life Members-sponsored mentorship event, psychiatric resident Alina Mitchell and I had a lively discussion about what's good, bad and in between on the large and small screen. I suggested we compose a freewheeling conversation about a movie or show from the perspectives of two MD's more than four decades apart in age and raised in distinctly different cultures and life circumstances. She agreed and suggested "The Pitt," a TV drama series that reflected the current state of medical practice with a unique format to be discussed below.

The traditional goal of a film or TV review is to criticize its merits as entertainment and art. We intend to focus more on the veracity of its subject matter and effectiveness to inform, inspire and provoke us as child and adolescent psychiatrists and trainees as we refine our skills in diagnosis, treatment, and prevention. In the case of this show, we also want to address how much it reflects the current state of our healthcare system.

In short, "The Pitt" is about a day in the life of a Pittsburgh emergency room staff who face far more than the expected variety of patient presentations. Its first season stretches over 15 episodes with each one representing a consecutive hour from the beginning to the end of a shift. We witness how well-trained and skillful clinical analytical people have to balance and often put aside their personal and professional struggles in the face of an unrelenting acceleration in the number of highly acute patients.

Peter: Alina, what made you suggest this series for our inaugural review?

Alina: For me, it felt like a natural progression of watching TV from adolescence to adulthood. I had previously dedicated a portion of my teenage existence to following the never-ending medical saga of "Grey's Anatomy."

Peter: Sorry if I offend you, but that one seemed too soap opera-ish for my tastes. But go on…

Alina: "The Pitt" comes closer to what I experienced as a med student and now as a resident. It's something I could share with my partner, who's a software engineer and who would never experience anything close to this in his line of work. I could protect the confidentiality of my patients, while he understood the clinical challenges I face as a physician. He was just as gripped, frequently horrified, and heartbroken by much of the action.

Peter: Gripped? Say more.

Alina: These shows by nature tend to ramp up the drama at an unrelenting fast pace…

Peter: Instead of their bogging down the action for a lengthy technical discussion about proposed interventions? Say more about being horrified and heartbroken.

Alina: The creators effectively employ the device of "jump scares"—loud, noisy, unexpected events—during bloody leg resets and thoracotomies. Then they pull you deeper into the horrors that can make you feel helpless. Take any situation where both patients and staff experience agonizing physical or emotional pain to the point of trauma or the loss of life. Adding to the list of heartbreak or hurt, I can identify with the "shock" of a young doctor who during one episode received negative feedback from an attending physician.

But back to the pacing. It accelerates with so many new patient admissions that results in an unmanageable backup in the waiting room. No wonder the "docs" portrayed on the show find little time to process their feelings. Between episodes, as a viewer, I found myself dwelling on the hurt that needed to be pushed aside as the action proceeded.

Peter: As a resident, I was taught to identify in myself a range of emotional responses when interacting with patients, but to take care about whether or not to express them. For example, are the hurt feelings we experience with patients secondary to a transference, countertransference, or interactional phenomena? In an emergent clinical situation, we were also trained to focus on the presenting problems and refrain from expressing emotions like hurt. We should revisit them later and run through a checklist to question if they were simply a delayed response due to the necessities of treatment, and if they have more subconscious, suppressed, or unconscious origins.

In that light, I'm reminded of a scene from the film "Three Kings." During the Persian Gulf war, the major played by George Clooney counsels a frightened young soldier who struggles to find the courage to go into battle: "The way it works is, you do the thing you're scared shitless of. And you get the courage after you do it, not before you do it."

Alina: Exactly. It seems at first a necessary tactic, though rushing ahead without processing an intervention that just happened or predicting what obstacles and consequences could lead to trouble.

Peter: If by trouble, do you mean a "normal" one, such as facing criticism from your supervisors and peers for your decisions or interventions? Or do you mean learning, heaven forbid, that you might have mismanaged the complicated medical course of a patient?

Alina: Both. I can deal with the first, but who wouldn't dread the second sort?

Peter: On that sober note, let's move on.

Alina: Yes, back to your favorite medical shows.

Peter: I was in high school from 1962-66, when "Dr. Kildare" and "Ben Casey" were neck and neck in popularity on TV. They inspired this impressionable and idealistic boy about the nobility of being a doctor. I remember these shows being good but not great. They employed a conventional straight line dramatic structure, then pumped it up with heart-throbbing stars, who were always white. Richard Chamberlain and Vince Edwards were skillful actors, but those shows reflected the era's tendency to create "message pictures." Kildare, Casey, and the cast couldn't proceed to the next case without emoting a self-important declaration about medical care and life in general that could range from maudlin to brooding too over-sentimental.

Alina: I don't know those shows, but would you consider "The Pitt" a breakthrough in television?

Peter: I'm not sure. It honors the legacy of well written and acted serio-comedic series from the 70's into the '90's. Especially "M*A*S*H", "St. Elsewhere", and "ER." Have you seen any of those older shows?

Alina: No, though I've heard a lot about them and that the finale of M*A*S*H was an event of the season at the time.

Peter: That show is still memorable. As our editor Dr. Drell commented on one of our earlier rewrites, "The Pitt's" shooting style could be "a breakthrough or just sped up like everything else" on TV and movies.

Alina: How unique is the concept of presenting a working shift in real time?

Peter: I think it's been attempted before over one or two episode or revisited in later episodes, but no one's stretched it over 15 hours. It pulls off each hour-long episode at a hyper pace, while deftly weaving multiple medical challenges combined with staff and patient interactions and conflicts. I'd love to see their story board, how they planned out each scene, and then watch the action from rehearsal through the actual shooting.

Alina: You feel like you can't catch your breath. As if you're going upstream without a paddle with critical lives in tow, and a perpetual tsunami lurking on the horizon.

Peter: Has that been your experience working in an ER?

Alina: It's near to authentic about the advances in acute medical treatment, as well as how the fault lines in our system of care place an unfair and unwanted stress on patients, families, and professionals.

Peter: My career in community-based psychiatry was dedicated to collaborating with others to fix those fault-lines on a county or state-wide level. That's a topic for a different essay but we knew back then the lack of a well worked out system of care was grinding everyone down.

Alina: So much so you might think about quitting and leaving the battle for optimal care for someone else to fight. And no, I don't have any plans to quit.

Peter: That's good to hear. I admire how the writers introduced in the first episode key "fault lines" while evaluation and treatment was going on. Here's some key examples: How the COVID-19 pandemic, though over, left devastating after-effects on the current delivery of care and on the well-being of patients and professionals. How an administration under budget restraints added additional pressure on a besieged and understa□ed service to improve patient satisfaction measures and the bottom line. How, as you mentioned, the ER became a holding cell. And just as important, how supervising physicians had to expend additional energy to tend to the educational, professional, and emotional developmental needs of its interns and residents.

Alina: During my psychiatric ER rotation, the doctors had no choice but to serve more needs and fill more holes in a broken system of care. And with millions now threatened with losing their Social Security benefits and Medicaid, a "Pitt" may be the only refuge for those who have health issues progressing to the brink, are seeking primary care, or simply needing a roof over their heads. The show captures the moral injury experienced by staff having the best intentions for their patients without the time, resources, or physical space to care for them as they hope to. I already who what it's like to have conversations with family members for days regarding the timing of discharge of children from the ED when it was still unsafe for them to return home or to foster care. I've also had to screen for suicidality in most unacceptable locations because of lack of space, such as in a packed overflow seating area.

Peter: What I admire about the show is that despite the potential for disaster it never stops on a hopeless note. Its sensibilities also differ from previous TV medical dramas, in reflecting modern literature and theater where the guiding dramatic principle is to "show, not tell." In other words, you "show" conflict by way of dramatization but never "tell" the audience though conversation or narration what it ought to think or feel.

Give credit to the creators, cast, and crew who, regardless of billing and cinematic experience, deliver great lines and construct visual setups that maintain a state of uncertainty, edginess, and hilarity in the most mundane or serious of situations. And kudos to the lead actor Noah Wyle, who was a young intern in "ER" and 25 years later plays "The Pitt's" chief of service. His knowledge, experience, and compassion help keeps his department afloat, though at a personal cost.

What about the show, didn't ring true for you?

Alina: Nothing in my training has ever been this dramatic (Spoiler Alert: not just one but two children's lives end simultaneously in one episode…was that really necessary?). But the bit about not having enough beds on the psych unit was definitely true.

Peter: My beef is that despite the ER having a very adept social worker, the lack of a psychiatrist and psychiatric team is glaring and unrealistic, especially in city or rural hospitals that serve are regional centers of cares. I must add that I completed a General/

C&A residency at Pitt in 1981. Back then, we even had 24-hour psychiatric ER apart from the hospital center's ER.

It the creators introduce a psychiatrist—or better yet, a team—next season, I hope we won't be narrowly typed as medication stabilization experts. We're trained to evaluate and treat from a bio-psycho-social perspective and to seek collaboration with other specialties and allied professions.

Alina: Our ED had a large team of psychiatric attendings, residents, and social workers constantly communicating with the medical ED staff to address behavioral crises.

There was one particular incident that actually made me yell at the TV.

Peter: Yell?

Alina: I'm known by those close to me to take TV matters quite personally. It's the scene where the doctor mismanages a case by hesitating to report a case to protective services. Those reports by law must be submitted based upon the suspicion of abuse and before confirmation. Our systems for addressing these issues are far from perfect, but they're far more precise and less avoidant than some of the methods depicted in the show.

Peter: Any last impressions about the show?

Alina: Was it perfect? No. The high levels and frequency of death and despair were borderline absurd.

Peter: But we're dealing with theatrical conceits, so I accept more unrelenting crises and the stretching of reality packed into one hour than an ED typically faces. In contrast, a documentary might reflect the normal pace of a unit but would be challenging to film because of privacy and confidentiality issues.

Alina: Yes, but Pitt's management of ethically complex situations was far from being by-the-book. And the tropes of the "competitive resident" and "dismissive attending" were too frequent.

Peter: What you describe as absurd, not by-the-book, and over-the-top I see again as within the bounds of dramatic license. The storylines work because the emergent situations and the actors' reactions are believable to an average viewer who is not a medical professional.

Alina: Well, criticisms aside, the show captures many moments when physicians can make a huge positive impact on someone's life. And how we also carry a burden when we're unable to make a positive change, or when those plans go awry. I'm fortunate to be able to put all of myself into the job with a wonderful support system to catch me when I need it, and to do the same for them.

Before we stop, what advice would you give trainees beginning a career in this kind of overrun, overwhelmed, under-resourced climate?

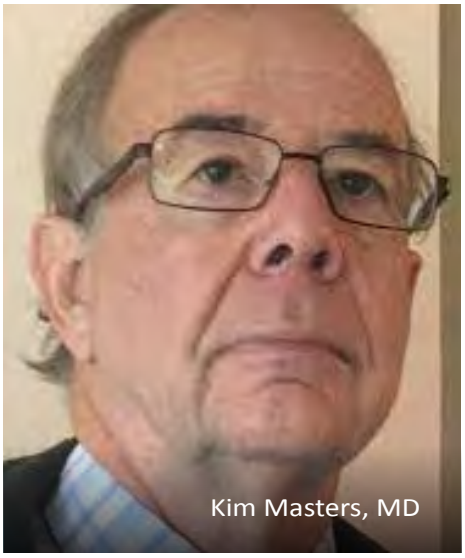
Peter: During this continuing crisis in the delivery of medical care, don't isolate yourself. Find a mentor—like the ones our Academy provides—and meet on a 1:1 basis. If possible, form a mentorship group and even, consider including a "Pitt" watch party as a way to spur discussion.

Finally, keep the conversation going about how to improve our delivery of care. While you're involved in very complex and emotionally draining work, find the time to discuss with your trusted superiors and peers what can be done to build a more coherent system that supports the work of everyone in the ER. And before it can seem all too much, plan a vacation to clear your head and give yourself some perspective.

Final note to our readers: Feel free to send your comments about this article concerning clinical and mentorship issues, the format of discussion, your reactions to the series, etc. Or catch us in person at the AACAP Meeting in Chicago. ■

Why We All Should Watch the Netflix Adolescence Series: A Movie Review and Commentary

By Kim J. Masters, MD, MA



With more than 114 million viewers to date, and critical acclaim,

Adolescence is an emotionally charged experience that encompasses Child Psychiatry: patients, families, and us.

A summary on Wikipedia states ," Adolescence is a British psychological crime drama TV series released on 13 March 2025. It was created by Jack Thorne and Stephen Graham and directed by Phillip Baratini. Its four episodes follows 13-year-old Jamie Miller who is arrested for the murder of his classmate, Katie Leonard. As the investigation unfolds, the series delves into themes of online radicalization, toxic masculinity, and the influence of the 'manosphere' on vulnerable youth. The narrative examines the psychological and societal factors contributing to Jamie's actions, offering a poignant commentary on contemporary issues affecting adolescents.

The Four Episodes

The third episode features the confrontation of Jamie's claim," I did not kill her" by a Forensic Psychologist. The other sessions examine the impact on Jamie's family of his stabbing Katie in a rage and then abandoning her to die, as premeditated revenge for her rejection of him. The effect on Katie's family is also included, but through the eyes of Jamie's family, his mother, father, and his sister. We see progression in this family from denial to acceptance, coupled with overwhelming grief at the impossibility of not being able to return Jamie to life as an ordinary teenager untainted by his lifelong sentence as a murderer.

Implications

- Both middle schoolers have absorbed their current adult cultural messages favoring competitive destruction of opponents. For Katie it was using internet humiliation to reject Jamie's dating requests. For Jamie it was seeking revenge and punishment for Katie, that were influenced by his persistent searches of the 'manosphere' 's misogynistic pornography.
- Both sets of parents were unaware of these influences as the events occurred outside their surveillance, in school, outside Katie's home, and on the internet.
- Jamie had attracted a group of like-minded boys who enabled his pornography searches and even furnished the murder weapon, without understanding that it was his call to action.

- Katie's peers also supported her online insults of Jamie, without appreciating the danger they created for her.
- The female forensic evaluator alternated from being friendly to repeatedly triggered hostility from Jamie, including misogynistic threats, and intimidation by his 'getting in her face,' refusing to sit down and throwing his chair across the evaluation room. His anger was triggered whenever she asked about his sexual activities, his father, his relationship with Katie, and his preoccupation with internet bulling from her and her friends about being so ugly that they would never date him. The interview is fascinating to watch because of the skills and chemistry between the actors that come across as frightening and real. There have been many issues raised about it, especially the professionalism of the psychologist in appearing to befriend Jamie, while confronting him, disclosing her personal information, and lack of structured rating instruments . It was also unusual that she insisted on continuing the interview despite verbal insults, demands, and physical threats .
- Jamie repeatedly blurted out, "I did not kill her" throughout this episode, it was unclear to me if he was consciously lying, or if this was denial that triggered a dissociation from the act.
- As Child Psychiatrists, this Netflix series could trigger individual responses informed by our clinical experiences. However, several general issues present themselves for comment.

Psychosocial Issues

- If we have patients and families who have watched this series, how should we foster discussions about it? Several themes seemed generalizable.
- he sins of the grandfathers and fathers are visited upon their children.
- Although an ancient aphorism, the episodes show its application to Jamie's own rage. The paternal grandfather was physically violent with Jamie's father. The father was also violent but limited assaults to destroying a shed. Afterwards, he bought Jamie a computer as an atonement against the violence.
- Unfortunately, Jamie had entrained his own capacity for rage into pornographic misogynistic websites, that offered him a rationale for killing Katie, because she had made fun of his longings to date her.
- "Spare the rod and spoil the child." In some American religious and cultural environments especially in the South, fathers are supposed to discipline children often with switches or belts. Tee shirts emblazoned with " Wait till your father gets home," are for sale on the internet. The oft cited religious rationale is Proverbs 13:24, translated in the New International Version as : "Whoever spareth the rod, hates their children. But the one who loves their children is careful to discipline them." However, an extensive twenty-year review by Durant and Ensom found that physical punishment of children is a risk factor for child aggression and anti-social behavior. The Adolescence series may trigger conversations with families in which discipline is carried out by spanking, particularly administered by fathers. Child Psychiatrists can sometimes use this scientific information to modify these practices, and they may be aided by church leaders with a broader and less punitive interpretation of the passage.
- The role of social media in the lives of pre and early teenagers was the subject of an AACAP News Article Media Committee authored by Shawn Sidhu MD in July-August 2015. It pointed out that "pre-adolescents or latency age children would not likely have the capacity to fully appreciate the impact and extent of their actions in the vast digital cyber world of today." This article validates the catastrophic consequences for both Katie and Jamie when they gained access to it.
- Thanks to Tik Tok, today, anyone with a computer or phone can easily connect to social media 24 hours/ day. The situation is ripe for abuse, because the market for children's purchases is an adult creation . The prolific author and Child Psychiatrist , Schuyler Henderson emphasized this intrusion in the paper, On the Teleological Perspectives in Child and Adolescent Development. He wrote,
- "This may seem natural and intuitive, but adult concepts of youth, including in the sciences of development, can lead to a teleological worldview in which the adult is seen as better , more important, more complex, and more valuable than the child." He continues, " Although

a desire to celebrate and nourish the integrity of childhood may often drive those who work with children, one cannot be sentimental about adult intentions, especially when so many adults can talk freely about of their love of children and childhood while globally, children are victims of widespread adult violence, including sexual and physical violence; bear the brunt of political violence, including warfare; and are widely exploited, including the production of goods used even by advocates for children (including manufactured clothing, chocolate, electronic products, and jewels")".

- The profit motive has created a class of child influencers, often supported or managed by their mothers for financial gain. Netflix has produced another series Bad Influences which details the experiences of these young people, whose interest in acting, robs them of their childhood, and substitutes instead a sexualized platform for pedophiles.

Summary

I hope that the Netflix series Adolescence will generate discussions among colleagues , child patients and their families, and that you will find that the series provokes discussions about similar situations in clinical practice. If you are interested in sharing insights with other AACAP Members, please consider submitting an article to the AACAP News. Contact email; rgrant@aacap.org. ■

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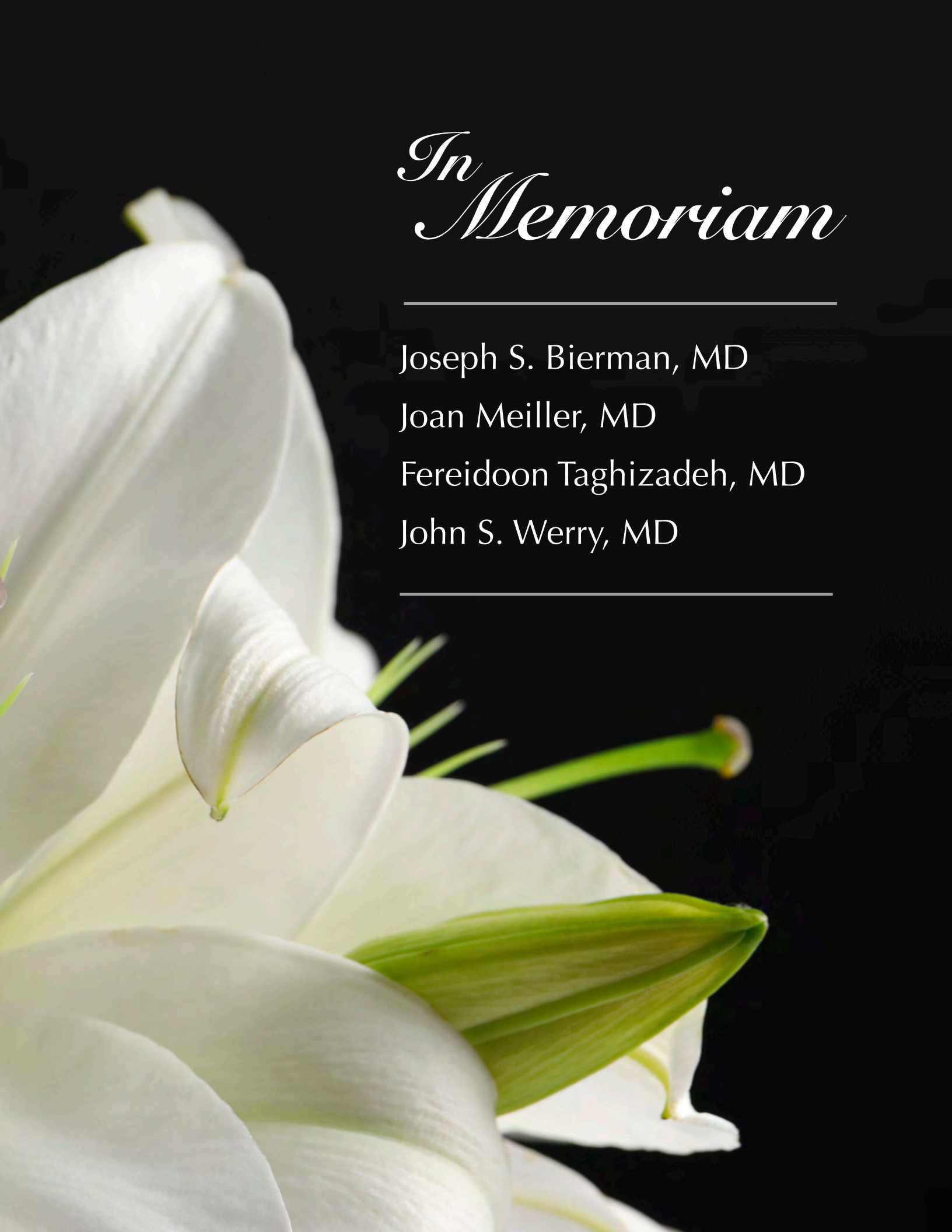
2. Bad Influences Netflix (2025) https://www.netflix.com/title/81688846
3. Grant J Ensom R. (2012). Physical Punishment of Children: Lessons from 20 Years of Research. Canadian Medical Association Journal. 184(12): 1373-1377, doi:10.1503/cmaj.101314
4. Henderson SW. (2023)Teleological Perspectives in Child and Adolescent Development. J Am Acad Child Adolesc Psychiatry.62(10): 1083-1085
5. New International Version of the Bible , Proverbs
6. Sidhu S. (2015, July August) Doctor When Should My Child Be Allowed to Start Using Social Media. AACAP News 46 (4). 169-170
7. https://en.wikipedia.org/wiki/Adolescence_(TV_series)



In Memoriam

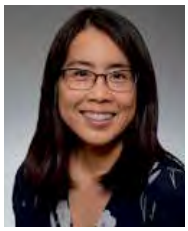
Joseph S. Bierman, MD

Joan Meiller, MD

Fereidoon Taghizadeh, MD

John S. Werry, MD

In Remembrance of My Mentor: Dr. Lois T. Flaherty



Liwei Hua

In addition to her many contributions to the field of child psychiatry, **Dr. Lois Flaherty** was a mentor to many child and adolescent psychiatrists. I am very grateful to have been one of her mentees.

Prior to meeting Lois, I thought a mentor was someone one respected and aspired to be like. Mentorship was not something I sought out, nor was it something that I considered necessary. But without my even knowing it, Lois became my mentor during the very first AACAP Adolescent Psychiatry meeting, which I joined as a new attending, fresh out of fellowship. I felt relieved, grateful, and lucky to find myself in a small room at a big conference, where I immediately felt welcome and comfortable enough to present a topic of interest and was then wholeheartedly supported and encouraged to submit this idea as a proposal for the next annual meeting. Her gentle and quiet manner of speaking belied her immense knowledge, expertise, and achievements.

It seems unbelievable to say that it wasn't until I went to a meeting where someone brought up the importance of mentorship and defined the characteristics of a mentor that I realized how important Lois was to me and that she embodied all the qualities of a mentor—and a strong female mentor at that. Through Lois, I realized that mentorship is active, not passive. She encouraged and supported me, nurtured my interests, invited me to join her in academic endeavors, bolstered me when I felt unsure, and applauded my achievements. Because of her, I have had opportunities at AACAP that I never thought possible at that first Adolescent Psychiatry meeting I attended. She encouraged me to be active in the committee, leading her to recommend me as the committee co-chair when she stepped down. That led to becoming AACAP liaison to the AAP Committee on Adolescence, which has led to other opportunities for scholarly activities with AAP and additional AACAP appointments. Lois encouraged me to write a chapter for a book she was working on with the GAP Adolescence Committee, and because of that contribution, I was invited to attend their meetings and eventually became a member. I truly believe that none of these opportunities would have been available to me had it not been for her consistent support of me and gentle nudging to consider every opportunity that came my way. Lois' mentorship of me inspired me to "pay it forward" and offer support and direction to interested trainees and ECPs in the AACAP Adolescent Psychiatry committee so that they, too, could actively engage in AACAP with presentations and writing.

Lois and I overlapped in places where we practiced and lived. Her early career was spent at the University of Maryland, where she was Director of the Child and Adolescent Psychiatry Services at the Walter P. Carter Community Mental Health Center (where I did part of my Residency training), Training Director of the Child and Adolescent Psychiatry at University of Maryland, and Director of the Division of Child and Adolescent Psychiatry. She spoke to me about her time in Maryland often. Lois was an advocate for school mental health, developing school mental health programs in Baltimore, and she founded the Center for School Mental Health at University of Maryland in 1992. This led to the formation of the National Center for School Mental Health, of which she was appointed Chair of the Advisory Board from 1995-2005. Lois was also an instructor at Harvard Cambridge, and I had done my fellowship training at a Harvard program as well, although I never directly overlapped with her there. Leadership roles included being president of the American Society for Adolescent Psychiatry (ASAP) in 1995

Professor John Werry: A Pioneer in Child and Adolescent Psychiatry



Jack McClellan, MD, Sally Merry, & Gabrielle A. Carlson, MD

Kua hinga he totara i te wao nui a Tane: A Maori Whakataukī (proverb) that means "The totara has fallen in the forest of Tane" (honouring the passing of a life of great importance).

Professor John Werry, one of the preeminent child and adolescent psychiatrists of the 20th century, passed away at age 94 on July 26, 2025. Professor Werry held academic positions at McGill, the University of Illinois and the University of Chicago before returning to New Zealand to create the Department of Psychiatry at the University of Auckland.

A former president of the International Society for Research in Child and Adolescent Psychiatry and a prominent contributor to the Academy of Child and Adolescent Psychiatry, John published and lectured widely, with seminal research addressing developmental psychopathology, ADHD, disruptive behaviour disorders, early onset psychosis and pediatric psychopharmacology.

Revered (and sometimes reviled) for his brilliant mind, artful wordsmithing and playful, at times, acerbic wit, John advanced critical thinking, evidence-based treatments and the investment in neuroscience as the basis for psychiatric disorders, long before these tenets were accepted by the field. A co-author of one of the earliest hyperactivity rating scales, John was asked for the story behind Quay, Werry and Peters rating scale. In typical John fashion he said that representatives from CIBA-Geigy, the original marketer of Ritalin, locked him and colleagues in a "cheap hotel with a case of beer" and told them not to come out until they'd developed a useful way to measure their drug's effectiveness.

John was a strong advocate for patients, families and equity in healthcare and medicine, his vision for research excellence and high-quality training in child and adolescent mental health was realized in the establishment, by others, of the Werry Centre for Infant Child and Adolescent Mental Health (now two centres, Te Aro Hāro and Whāraurau). He worked tirelessly to improve clinical psychiatry services, both at the tertiary in-patient centre in Auckland, and in far flung rural areas. He was influential in the creation of Youth Horizons Trust (now Kia Pūawai) to help young people dealing with behavioural, emotional, mental health and development issues. The perfect epitaph for John is one he gave himself many years ago when he compared himself with the humorless bores who often populate a medical school faculty. He called himself a Larrikin—an Australian term meaning "a mischievous, rowdy but good-hearted person who acts with apparent disregard for social or political conventions"

Professor Werry leaves behind his wife, Dianne Moffit, five children, 12 grandchildren, three great grandchildren and a lifetime's treasure of grateful trainees, mentees, friends and colleagues. We will miss him.

Jack McClellan, Professor University of Washington

Sally Merry, Professor Emeritus, University of Auckland

Gabrielle Carlson, Professor, Renaissance School of Medicine at Stony Brook University

He called himself a Larrikin—an Australian term meaning "a mischievous, rowdy but good-hearted person who acts with apparent disregard for social or political conventions"

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AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. We are deeply grateful to the following donors for their generous financial support of our mission. **Gifts Received from January 1, 2025, to August 25, 2025.**

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at **development@aacap.org or 202.966.7300.**

Thank you for supporting AACAP!

AACAP Opposes Removal of 988 Crisis Line Support for LGBTQ+ Youth

Washington, DC - The American Academy of Child and Adolescent Psychiatry expresses deep concern over the decision to eliminate specialized 988 crisis services for LGBTQ+ youth. This change removes vital support for young people who already face significantly higher rates of depression, anxiety, and suicide risk.

LGBTQ+ youth deserve access to developmentally appropriate, culturally competent crisis care. Removing dedicated support weakens that care and increases the risk of preventable harm.

AACAP calls on policymakers to restore these services and ensure that all youth, especially those most at risk, have access to the support they need to stay safe and healthy.

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health. For more information, please visit www.aacap.org

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AACAP Reaffirms Commitment to Gender-Affirming Care Following Supreme Court Decision

Washington, DC - The American Academy of Child and Adolescent Psychiatry (AACAP) is deeply disappointed by the U.S. Supreme Court's decision to uphold Tennessee's ban on gender-affirming medical care for transgender adolescents.

This decision denies access to evidence-based, developmentally appropriate, and often life-saving medical care for transgender and gender-diverse youth, including those with gender-related stress or gender dysphoria. It disregards clinical consensus and undermines the ability of families and physicians to make decisions in the best interest of their patients. AACAP urges policymakers to support the physician-patient relationship and ensure that health care remains guided by clinical expertise, not political ideology.

We reaffirm our longstanding support for comprehensive, multidisciplinary, trauma-informed gender-affirming care. We oppose efforts that restrict access and support continued research to improve outcomes. AACAP stands with transgender youth and their families and remains committed to advancing policies that promote health, safety, and dignity for all children and adolescents.

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AACAP Releases 2025 Election Results

The 2025 American Academy of Child and Adolescent Psychiatry election concluded on May 31, 2025 at 11:59 pm EDT.

The following members terms will begin at the close of AACAP's 2025 Annual Meeting.

President-Elect (October 2025-2027)/ President (2027-2029)/ Past President (2029-2031)
- Timothy E. Wilens, MD, DFAACAP

Secretary (October 2025-2027)
- Sala Webb, MD, DFAACAP

Treasurer (October 2025-2027)
- Barry Sarvet, MD, DFAACAP

Councilor-at-Large (October 2025-2028)
- Alicia A. Barnes, DO, MPH, DFAACAP
- Jennifer Creedon, MD, DFAACAP

Nominating Committee (October 2025-2027)
- Liwei L. Hua, MD, PhD, DFAACAP
- Jonathan J. Shepherd, MD, DFAACAP

These elected members are well-respected leaders who have consistently demonstrated their support and dedication to the mission of AACAP and its members. We wish them all the best in their new positions.
Thank you to the Nominating Committee, led by Dr. Warren Ng, for their efforts in selecting a terrific slate.

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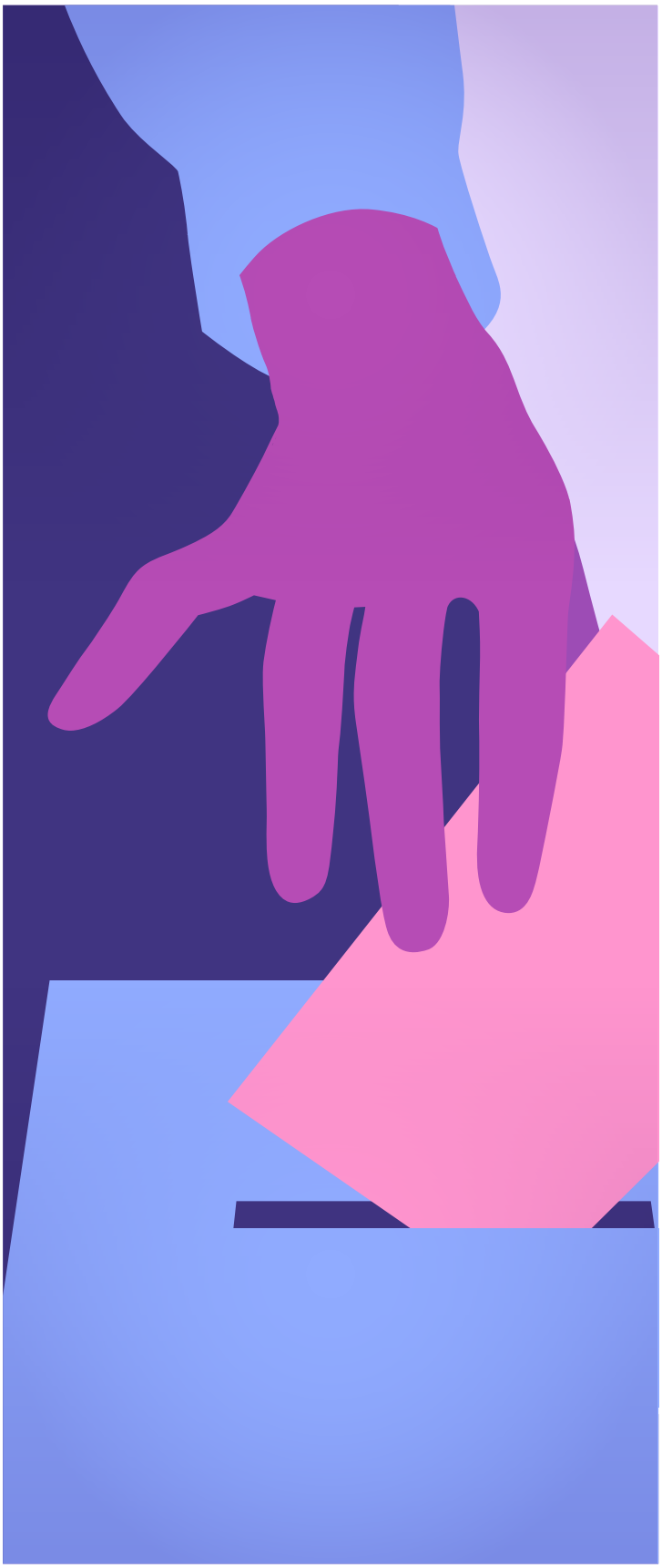

AACAP Statement on Psychiatric Medications and Children's Mental Health

Washington, DC - The American Academy of Child and Adolescent Psychiatry (AACAP) recommends that all treatment decisions, including the use of selective serotonin reuptake inhibitors (SSRIs), be made collaboratively by medical providers, patients, and families to ensure safe, effective, and individualized care.

Psychiatric medications, including SSRIs, are safe and effective when prescribed and monitored by licensed medical professionals. Despite recent headlines to the contrary, decades of rigorous research and clinical experience show no evidence that SSRIs cause violence. For many children and adolescents, these medications can be lifesaving by reducing symptoms, restoring functioning, and supporting recovery.

When clinically appropriate, SSRIs are a valuable treatment option for depression, obsessive-compulsive disorder, and anxiety disorders. Prescribing decisions follow comprehensive evaluations by trained physicians working closely with families. Medication is always one part of a comprehensive treatment plan that includes psychotherapy, school-based supports, and family involvement.

AACAP remains committed to advancing evidence-based care that promotes healing, resilience, and well-being for all young people.

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Policy Statement on the Care of Pediatric Patients Awaiting Psychiatric Care in Emergency Departments

Background

Limited availability of inpatient psychiatric beds leads to the practice of "boarding" patients in emergency departments (EDs) or other acute medical settings. The Joint Commission defines "boarding" as the practice of holding patients in the emergency department or another temporary location after a decision has been made to admit or transfer them.

While the Joint Commission recommends boarding times not exceed 4 hours, national averages can be days to weeks or even longer. Risk factors associated with prolonged boarding include younger age, behavioral escalation, homicidal ideation, concurrent chronic physical illness or somatic complaints, comorbid eating disorder, comorbid neurodevelopmental disability, serious mental illness (e.g., mania, psychosis, and severe suicidal behavior), and youth with complex psychosocial situations (e.g. attachment difficulties, foster care involvement, unstable insurance status).

Though boarding in the ED may provide a safe environment, it often lacks access to ongoing, evidence-based mental health evaluation and treatment needed to address clinical needs of this acute patient population. This is a missed opportunity for stabilization and, for some patients, consideration of potential discharge to a lower level of care in the community. Furthermore, prolonged boarding can negatively impact patient and family wellbeing, increase the risk of further behavioral escalation, and can significantly impact ED workflow and resource utilization.

To improve the care of pediatric patients awaiting psychiatric care in emergency departments, the American Academy of Child and Adolescent Psychiatry recommends:

- Working with stakeholders to provide a therapeutic, safe environment for mental health care delivery, support structure, and activities of daily living in emergency departments, inpatient psychiatric units and outpatient mental health care programs.
- Support for training and education of both mental health and non-mental health professionals in the assessment and management of pediatric psychiatric concerns in emergency and crisis settings.
- Advocacy and funding for the research and development of evidence-based diversion protocols and implementation of clinical pathways and alternate services to support youth boarding in emergency and crisis settings.
- Mental health parity for all patients and equity for all populations to have timely access to both higher (inpatient) and lower (partial hospitalization, crisis, or outpatient) levels of psychiatric care that best meet patients' needs.

The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

Approved by Council July 2025

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