LifeMember
OWL NEWSLETTER

Spring Edition 2023 e-Newsletter

Welcome to the Spring Edition of the Owl News!

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

Quotes On Inclusion

"It is time for parents to teach young people early on that in diversity there is beauty and there is strength."

— Maya Angelou

"Diversity happens, Inclusion is a choice."

— Harjeet Khanduja

An individual has not started living until he can rise above the narrow confines of his individualistic concerns to the broader concerns of all humanity."

— Martin Luther King, Jr

"It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences."

— Audre Lorde

"The human heart is too grand to be wasted in the gutter of cultural exclusivity."

— Abhijit Naskar

"We believe our diversity makes us stronger, smarter, and more innovative, helping us better serve the needs of our clients, our people and our communities."

— Julie Sweet

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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

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COVER ART:

The start of spring is a time of renewal and rejuvenation, as the world awakens from its winter slumber. As the days grow longer and the weather warms up, the landscape begins to burst with vibrant colors and new life. Spring is known for its pastel colors, with delicate shades of pink, purple, yellow, and green dominating the palette. Flowers such as tulips, daffodils, hyacinths, and cherry blossoms bloom during this season, adding pops of color to gardens and parks. The sight of these colorful blooms and the sweet fragrance they emit are a sure sign that spring has arrived.

– Rob Grant

American Academy of Child & Adolescent Psychiatry

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AACAP 2023

NYC October 23–28

Visit www.aacap.org/AnnualMeeting-2023 for the latest information!

Save the Dates

Call for Papers Deadline: **Feb 15, 2023**

New Research Poster Deadline: **June 7, 2023**

Preliminary Program Available: **June 15, 2023**

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The Beauty of Spring - 2023

By Cynthia Pfeffer, MD

Cynthia Pfeffer, MD

Each year, we applaud the advent of the new spring season with its awakening and flowering beauty that brings a sense of renewal,

liveliness, hope, joy, planning, the opportunity to rejoin outdoor activities, and e experience pleasing new pursuits and emotions. I resonate with this sentiment, especially since I have just retired and am experiencing the importance of beginning new activities at the time of retirement. Recently, I was asked by Marilyn Benoit, MD. and Martin Drell, MD. to write my final Life Members Co-Chairs' article as I have officially moved off the Life Members Committee. It has been an honor to be the co-chair of this Committee for many years. I have seen the Life Members Committee "blossom" in its focus on promoting fine plans for the Life Members activities, including new Life Members at large, and planning initiatives to enhance the development of medical students and child and adolescent psychiatrists. We traversed the difficult times related to the COVID-19 pandemic that made it impossible to hold meetings in person. As we processed these challenges, we became stronger as a group and developed means to utilize zoom for our interactions and conducting our Life Members programs. I was pleased to help cope with these difficult times and maintain strongly functioning programs. We have a fine roster of Life Members on our committee and at large to engage in important planning for our field of Child and Adolescent Psychiatry. We have developed a strong cohort of medical students and child and adolescent psychiatry residents who have become active in working with the Life Members Leadership to promote their development as future leaders in our field.

Limiting one's work and personal activities are processes that we inevitably face as we age. Like many other AACAP Life Members, I am at this phase of development. As stated before, I recently completed my status as a member of the Life Members Committee and entered the group of Life Members at large. While I regret not being closely active on the Committee, I cherish the work I contributed to its functioning. I look forward to continuing the field of Child and Adolescent Psychiatry in my role as a Life Member.

Recently I retired from some of my work roles at Weill Cornell Medical College and have become an Emeritus Professor of Psychiatry. I will continue some of my academic work involving publishing, teaching, and interactions with staff and students at Weill Cornell Medical College Department of Psychiatry.

Retirement is a special phase of life for a psychiatrist who chooses to permanently leave the workforce. It involves the important processes of planning financial, social, health, family, and patient care situations to make a stable personal transition into this new phase of life. It is important to plan to be more involved with family, friends and develop new satisfying relationships and activities. It was essential for me, as a retiring psychiatrist, to ensure each of my patients make a smooth and beneficial transition to be treated by another psychiatrist. This important task significantly affects a patient. I will continue, at a limited pace, the Life Members group of AACAP, and at other professional activities. Being active

professionally and socially is important to me and helpful to develop new ideas and experience the joy of contributing to society at large. Please call on me to be actively involved with AACAP activities.

Retirement means experiencing and maintaining life's activities that are enjoyable, feasible, and positively special, such as the feelings derived from viewing "the beauty of spring flowers". It means giving up many, if not all, work activities and incorporating new feasible activities with family, friends, and community endeavors. It involves continued learning. It is a time of life in which vitality of mind and action need to be maintained and nurtured but often with modification of intensity. It means the potential for receiving physical and or/mental help to maintain healthful experiences and activities. Of great importance is maintaining one's positive perspective on feelings, activities, personal sense of belonging, being able to help others, and receiving gratification of entering a new phase of the life of elders, who can provide collective wisdom about being fulfilled by life's experiences.

All the World's Alive Again

by Jennifer Gunner

The rabbit hops its gentle step
The lark sings lyric songs
All the world's alive again
Spring rights the winter's wrongs. ■

WE WANT TO HEAR FROM YOU!

We're requesting articles, film reviews, book reviews, documentary review – and suggestions!

In addition, have you seen or heard a TED Talk recently that set your hair on fire? If so, we want to know!

Please send interesting articles, book/film reviews – anything you think the Owl Community would benefit from knowing about to communications@aacap.org.

Life Members as a Resource for Articles about Grandparents

By Kim Masters, MD

The December 2022 issue of the JAACAP featured an article on a proposed scientifically based Journal written in text understandable to parents. The goal is to provide them with articles created on a peer reviewed Journal couched in understandable presentation and language.

The link to the JAACAP article is:
https://www.jaacap.org/article/S0890-8567(22)00114-9/fulltext

Although the Journal is not yet in its final form, including articles from grandparents' perspective would be valuable. In my clinical works, I have observed grandparents influencing psychiatric treatment of their grandchildren through opinions expressed directly to the family, and covertly through positive, ambivalent, or negative attitudes toward mental health consultations. I am certain that you also have seen examples of this especially in communities where grandparents are integrated into the life of the family. For example, Marty Drell wrote an OWL Newsletter article in the October 2017 Issue which explored Grandparenting both as a personal and an evidenced based set of profound advice.

There is a plethora of advice about pediatric mental health available online. However, there is a dearth of evidenced based data to evaluate these recommendations.

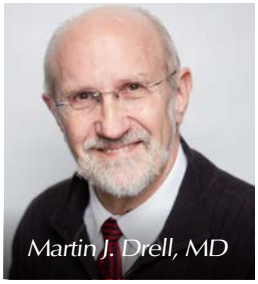
Our Life Members would be in an ideal position to author, promote, and encourage the development of articles on Grandparent issues given their own clinical and personal experiences. One goal of this submission is to create a forum for these grandparent articles. The editor of this new Journal is Gal Shoval, and his email is: shovgal@tauex.tau.ac.il

You can contact him directly.

The other goal is to see if there would be an interest among Life Members in having a forum for discussing Grandparenting from both a personal and an academic perspective. The organization and activities of the group should be developed by participants and possibly include periodic audio and/or video discussions, emails, and in person discussions at the annual AACAP meeting. Whether it should be under the auspices of the OWLS or should be simply an independent group of Life Members, should become clear as the forum membership develops. ■

An Impostor's Take on Impostor Syndrome

By Martin J. Drell, MD


Martin J. Drell, MD

A young entrepreneur I see for therapy had been the COO of a successful startup and moved on to start her own company. Soon after the start, she talked about her trouble returning emails that she routinely and effortlessly did in her previous position. She was upset with herself and told me she felt like an "impostor." As the phrase came out of her mouth, I realized that she was one of several of my patients who had lately accused themselves of the exact same feelings. I noted that there seemed some sort of "trend" going on that seemed useful in capturing how they were feeling. I knew what to do in therapy. I asked for her to tell me more about her feeling of being an impostor with the goal of trying to understand what was going on. Despite this, I made a note to myself to read up on impostor syndrome and see what others have thought about it.

There turned out to be an abundance of information in the form of academic journals, magazines, websites, and blogs. It is indeed a well-known phenomenon. Most authors agreed that phenomena was coined by Pauline Clance and Suzanne Imes in the 1978 article titled, "The impostor Syndrome in High Achieving Women: Dynamics and Therapeutics." The authors report that the concept has slowly gained recognition and relevance in popular culture. Clance and Imes noted that these women do not experience an internal sense of success despite being objectively successful as judged by awards and promotions. The "competent" women they described had an ongoing internal sense of self doubt that translated into a sense of being "frauds" that would inevitably be "found out" and exposed. When asked how they had been so successful to that point, their women subjects said it was due to luck or compensatory overwork on their part. Their sense was that if they didn't overwork that their deficiencies would be discovered with subsequent bad consequences. Melody Wilding laughingly refers to the syndrome as a "hot mess of harmfulness."

Valerie Young, PhD, in her book, "The Secret Thoughts of Successful Women: Why Capable People Suffer from the Impostor Syndrome and How to Thrive in Spite of it", breaks those with the syndrome into five very interrelated and overlapping subgroups. These are:

The Perfectionists: This group sets excessively high goals and pays the price for not meeting them. These perfectionists are seldom satisfied and may project their expectations onto those who work for them with subsequent micromanagement and problematic delegations. They don't realize that not all efforts need to be 100%. I often remind such persons that a 93% is still an "A." They seldom agree and are equally skeptical of Winnicott's concept of being "good enough." They are not able to have "radical compassion" for themselves.

The Superwomen: This group compensates for their sense of incompetence by pushing themselves to work longer and harder. They become super "workaholics" with few outside interests. They are on a treadmill of their own making that has its incline and speed settings constantly increased. They are "good" girls working for external validation.

The Natural Geniuses: This group feels that they need to be or are raised to believe they are "geniuses" who should "effortlessly" succeed. When they don't succeed, they feel deep shame. This category reminds me of the work of Carol Dweck that describes two mindsets depending on where people feel their abilities come from along a nature-nurture continuum. At the nature end of the continuum are those with a "fixed mindset" who feel their success is due to innate ability while at the nurture end of the continuum are those with a more flexible "growth mindset." Dweck's research shows that those with "fixed mindsets" often do poorer, as they want to look smart and avoid challenges that might challenge their genius status. Dweck favors a parenting style that validates flexible efforts that promotes a growth mindset.

Upon reading her work, I couldn't help but to associate to a few, quite intelligent medical school classmates of mine who, after getting straight A's their entire lives, found themselves competing with others in medical school of equal, if not better standing, and promptly academically crashed and burned."

The Soloists: This group feels that asking for help will reveal their deficiencies and therefore, condemn themselves to doing things on their own. I used to joke that I always studied alone because if I felt the person I was studying with was smarter than I, I'd feel bad and if I felt they were dumber than I, then what would I gain.

The Experts: This group bases their sense of competence on what they know and can do. They are constantly driven to learn more and more, not for the joy of learning, competence, or helping others, but for fear of not being found to be lacking. As Satchel Paige said, "Don't look back. Something might be gaining on you."

Each of these 5 subtypes appear to represent different strategies for dealing with the pain of feeling inadequate. One can see that each of these subtypes sets in motion dynamic cycles of defensive/coping mechanisms that in turn cause new problems that must in turn be dealt with - - on and on, ad infinitum. These strategies are driven by the double bind of having to deal both with the consequences of failure as well as of success. These strategies translate into behaviors that are all too familiar to therapists, administrators, parents, and friends. They include perfectionism, procrastination, problems in prioritizing, collaboration, communication and delegation, cheating, sensitivity to criticism, self-criticism, scapegoating of others, a sense that one is constantly being monitored, various forms of self-sabotage (n.b., "shooting yourself in the foot"), not asking for raises or promotions, or quitting one's job for fear you are about to be fired. It also includes many signs and symptoms of burnout that are associated with psychiatric distress, especially depression and anxiety.

Research on Impostor Syndrome since 1978 has clarified that this is not just an affliction of women and extends to men. The research shows a steady increase over time in those thought to have impostor syndrome to a whopping estimate of 70% in the U.S. An article by Felder humorously titled "Impostors Everywhere" nicely highlights this burgeoning trend.

Theories about the etiology of Impostor Syndrome are multiple. This list of usual "nature-nurture" suspects identified are:

- **Biological risk factors for anxiety and depression.**
- **Early family dynamics and parenting.**
- **An introjection of problematic societal sex role stereotypes.**

Cartoon used with permission from www.bizarro.com

A parallel inculcation of our societies values with regards to what is valuable and worth striving for. Capitalism is certainly up for scrutiny with its focus on money, success, and power. I often exemplify this with what I call the "Hollywood" mentality that focuses on what you've done lately and the adage that you are "only as good as your last movie – and its gross."

Persons with dynamic therapy training can certainly see a cavalcade of ego defenses in action trying to deal with the numerous underlying conflicts involved. They would also highlight the linkages to problematic development, parenting techniques, and fragile narcissism.

Many articles on the topic suggest a plethora of ways to address "Impostor Syndrome." They include calling attention to the syndrome (n.b., self-awareness) and educating people that they are not alone in either their feelings or their actions (n.b., misery is helped by company). Presentations on the topic and support groups have been suggested as helpful.

As expected, this has been a focus of CBT techniques that attempt to clarify the extent of the problem, what the person has tried so far, differentiating feeling incompetent and actually being incompetent, identifying faulty attributions and perceptions and their subsequent actions, challenging the validity of the attributions, trying new activities, tracking the success of these new activities, the repetition of successful efforts (as I say, "then do it a thousand more times!"), and an intimate knowledge of the Serenity Prayer. Aspects of positive psychology, which has been increasingly subsumed under the ever-enlarging tent of CBT, are often mentioned. These include taking care of yourself, deep breathing and other relaxation strategies, mindfulness exercises, and compassion for yourself ("quit beating yourself up!") and others ("Be kind, as everyone is carrying a heavy load").

If these therapeutic strategies don't work, I would suggest other psychodynamically informed therapies that might be helpful in understanding the etiologies of this syndrome, especially if they are out of the awareness of the person. I note that this phenomenon is familiar to most psychodynamic therapists who have their own names for it whether this be neurosis, ABD – All but Dissertation syndrome, those wrecked by success (Fenechel), narcissism, poor self-esteem, etc.

Seritan and Mehta, in their excellent article, "Thorney Laurels: The Impostor Phenomenon in Academic Psychiatry," focuses on the individual strategies listed above, but add specific strategies for academic institutions. Their list suggests that academic institutions should:

- **Provide educational workshops on impostor phenomenon for faculty and staff.**
- **Develop mentorship programs, in general.**
- **Design specific, targeted support and mentorship programs for international medical graduates and underrepresented minorities in medicine.**
- **Offer leadership training and coaching.**
- **Foster a "growth" mindset culture that does not punish mistakes.**
- **Factor aspects of Impostor Syndrome into the academic processes of promotion and remediation.**
- **Factor aspects of Impostor Syndrome into Employee Assistant Programs.**
- **Factor aspects of Impostor Syndrome into existing programs addressing burnout and wellness especially for faculty new to their positions and/or in transition.**

As my target audience is child and adolescent psychiatrists, I will end with a note on parenting, which is a potential prevention strategy. Several authors focus on parenting specifically. They point out that parents with Impostor Syndrome are likely to spawn a next generation of Impostors. To reduce the possibility of such, the parents should be aware of the syndrome and use the individual strategies above to help themselves and, therefore, subsequently help their children. The parents should be aware of the messages they send out as far as what they value and expect. They should promote Dweck's "growth mindset" and be careful of what they criticize and validate. They should avoid the idea of "you are no good unless you're good," styles of parenting, which lead to overly obedient children who are afraid to talk about their feelings even if those cases when they actually know what they are. Winnicott's concepts of being "good enough" (vs. perfect) and the "false self" would seem to factor into any formulation.

The parents should generally praise their children for specific positive achievements and do so frequently. They should pay attention to their actions with the knowledge that their children are looking to them as role models. Children should be raised by their parents to know that the parents are not perfect, can make mistakes, and can apologize. Parents should help their children make decisions and to accept the consequences of them. Similarly, they should teach that some problems do not have great solutions and that some may have none. This allows children to internalize the concept of being "good enough" developmentally as well as an appropriate sense of their limitations. Finally, parents should be aware of helicoptering which involves doing things for their children that the children can do for themselves. This act of enabling robs their children of

opportunities to practice and master valuable skills and, at the same time, sends the message to their children that they don't have the skills to do things themselves. Helicoptering is a process by which parents try to reduce the anxiety in their children. It works well in the short run, as it temporarily avoids and reduces anxiety, but is harmful in the long run as it tends to leave children feeling incompetent and potentially sets them up for a future life as an impostor. More insidious is the reality that the parent's actions are often based on their own anxiety, which creates a mutually reinforcing process that reduces anxiety in both parties. Such parent and child interactions has been suggested as the etiology for some of the problem's millennials are accused of having (See Simon Sinek), even though impostor syndrome as an entity long predates the much talked about and often maligned generation of millennials. ■

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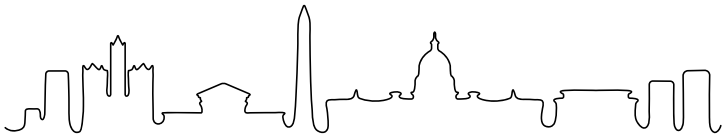
American Association of Child & Adolescent Psychiatry

AACAP 2023 LEGISLATIVE CONFERENCE

MAY 8-9, 2023

Washington DC



FOR MORE INFORMATION, EMAIL
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AACAP is pleased to announce the 2023 Legislative Conference in Washington, DC May 8th and 9th, the first in-person Legislative Conference since 2019. This annual event is key to help advance AACAP's federal legislative priorities and an important time for AACAP members to develop relationships with their members of Congress. Legislative initiatives that did not become law in 2022 must be reintroduced in the 118th session of Congress. It is essential that Congress hears from AACAP members that more needs to be done to improve access to high-quality children's mental health care.

Why Are There Five Hundred Plus Types of Psychotherapy?

By Martin J. Drell, MD

"What's in a name? That Which We Call A Rose By Any Other Name Would Smell As Sweet."

Shakespeare

Martin J. Drell, MD

During a discussion on psychotherapy, a colleague asked the provocative question as to why there are five hundred plus types of psychotherapy and not five hundred plus types of psychopharmacology. Embedded in his question was a worrisome sub-question as to why so many of these psychotherapies are based on psychodynamic theories and practices, yet do not indicate this fact in their names? Does the reality of having so many therapies really make a difference? I would contend that it does, if only because it is confusing, especially to the average consumer of therapy who does not know which therapy to choose.

One wonders why the creators of these therapies, especially those that are psychodynamically informed, do not do a better job acknowledging their ancestry? The following hypotheses come to mind as reasons for this lack of attribution:

Perhaps this is because the creators assume that they do not need to, as the ancestry appears self-evident. In this current age that is not necessarily fond of history or reading this is clearly a problem.

Perhaps it is because the creators have purposely done so to distance themselves from psychodynamic psychiatry which now suffers from bad press and stigma from various now repudiated theories that Freud and his followers espoused over a period that spans from the Victorian Era until today. The fact that psychodynamic theories were created by differing persons for differing clinical situations and patient cohorts and have been revised over time is often neglected in our current culture in which people and their theories', in totality, can be canceled for one perceived, politically incorrect aspect of the totality.

Perhaps it is due to entrepreneurial, capitalistic, and/or narcissistic reasons which prefer "new" products over "old ones." Few products, and don't believe

that therapy is not a product, promote themselves by saying they are "me too" products, just like their predecessor. This would not be good for business. Instead, the products are given new names and hype, despite their differences being small and often without

substantial evidence to back up their claims.
Focusing specifically on the psychodynamically informed therapies, another possibility is that the proliferation of this therapy is due to the troubles the psychodynamics field has had coming up with a consensus definition of what psychodynamic psychotherapy is. I believe that this includes not clearly differentiating and articulating its origins that derive from distinct psychoanalytic theories and psychodynamic psychotherapies created by distinct populations and problems. I quite enjoy the rigorous debates over these complicated issues, but I do not feel this is good for branding nor our public relations and advocacy.

Another related possibility, at least in part, is due to the fact that early on, psychoanalysis and psychodynamic psychotherapy never saw the need to do research due to its long period of hegemony. This hegemony and the lack of clarity as far as its definitions mentioned above, definitely impeded research. It is hard to do research without a clear sense of what is being researched. Historically, at the inception of psychoanalysis, research was not the top priority it is at present. As the importance of research was more clearly appreciated, psychoanalysis impeded its ability to do research by its exclusion in the US of those non-MD disciplines who are often trained to do research. It is now clear that psychodynamic psychotherapy often by non-MD analysts, can be researched, and when done so, is often evidenced based to the standards of the day. Fortunately or unfortunately, depending on one's viewpoint, contemporary research is often done for the newer, psychodynamically informed therapies which may not include the word "psychodynamics" in them. (Examples: Metallization, Child-Parent Psychotherapy, Regulation Focused Psychotherapy for Children). This lack of attribution has proved costly to the promotion of psychodynamic therapy as a field.

Another contributing factor appears to be the fact that therapists end up sub-specializing in specific types of therapy, such as psychodynamic, CBT, or family therapy. Whether this is due to the fact that trainees are unduly influenced by their training and who trains them (n.b., we are all victims of our training) the "cult" of leadership and associated with each type of therapy, the perceived differences associated with specific therapies, multiple financial incentives, or other factors is unclear. For whatever reasons, perhaps the "medical model" and the long tradition of using more than one medication at a time, the psychopharmacologists have not chosen to see themselves as aligned to one type of medication. The reality is there is not the perception that there on five hundred types of psychopharmacology.

This proliferation of therapies, over time, is not just in the sole domain of psychodynamic therapy. Has not the same phenomenon occurred in CBT, which has evolved over time, since the 1940's? It evolved out of behavioral therapy and continues, like psychanalysis, to expand as it turned its theories and practices to the challenge of dealing with new patients, with new diagnoses in differing developmental age ranges. Hayes, in 2004, proposed that the evolution of CBT has occurred in three successive waves.

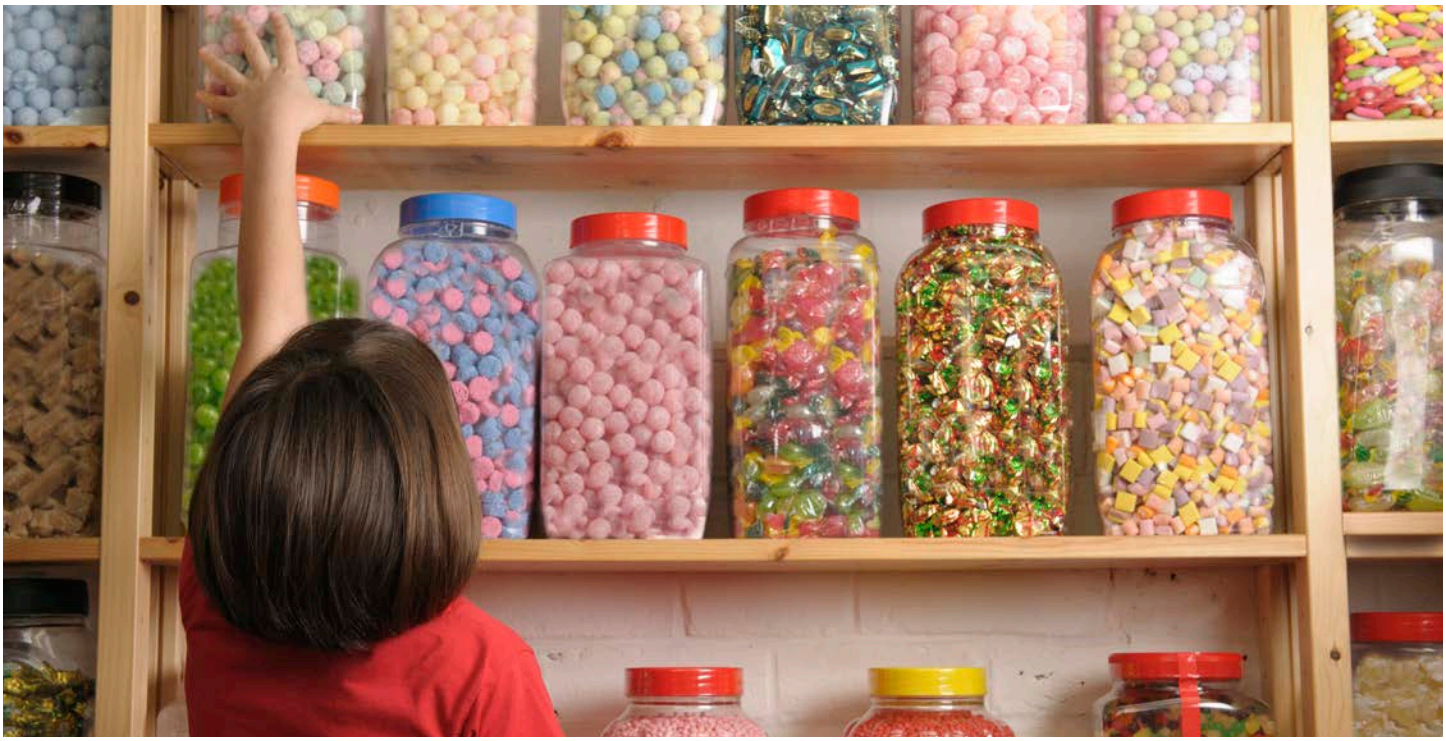
1) Behavioralism – operant and classical conditioning,

2) Cognitive and Behavioral therapy – Ellis & Beck,

3) Introduces spiritual teachings and mindfulness (Acceptance and commitment therapy, Schema Therapy, DBT, and Mindfulness based Therapies).

Many of the various types of therapy can be traced back to their behavioral and cognitive roots. Like with psychodynamic therapies, many CBT derived therapies do not specifically mention CBT in their names (examples: Acceptance and Commitment Therapy, Somatic Experiencing Therapy, Mindfulness). This has also led to similar discussions over definitions as to what constitutes CBT, as well as a plethora of specific manuals for therapists and consumer use. These manuals are certainly good for business, but not for therapists whose bookshelves and book budgets are ever expanding. At present, this proliferation is being addressed by David Barlow, who is creating a "unified" protocol that is "transdiagnostic." Where splitting occurs, will not clumping eventually follow? Perhaps, psychodynamically informed therapies could benefit from similar "unified" efforts that address the similarities vs. the differences in all of its related therapies.

A still larger issue relates to the fact that the larger field of psychotherapy research has never definitively determined what factors account for success in psychotherapy. Many therapies preferentially focus on cognitions, behaviors, or emotions. For example, behavioral therapies focus on behaviors, CBT, which evolved from behavioral therapies, focuses on cognitions/cognitive distortions, and psychodynamic therapies focuses on emotions. My take is that this is a



foreground/background issue and that all therapies "systemically" end up dealing with all three of these key interrelated foci. As an example, a shift in cognition inevitably leads to changes in behaviors and vice-versa. And if that isn't problematic enough, many psychotherapy researchers contend that the main curative factors in therapy have much more to do with common factors, such as the quality of the therapist-patient relationship, which seems to be considered a background issues to those many therapies which focus preferentially on feelings, behaviors, or emotions. The emphasis on "common factors" might explain the oft noted phenomenon that "master clinicians," regardless of the schools they espouse, appear similar in what they actually do during sessions. A recent 2021 article by Goodman, Calderon, and Midgley suggests that common and specific factors both contribute to therapeutic success. Let the research continue!

In reality, whether we like it or not, there are five hundred plus types of therapies. I can see little reason why the number will not continue to grow over time for the reasons I allude to in this article and many more I undoubtedly have failed to mention. I do not feel that this is good for psychodynamically informed therapies specifically, or psychotherapy in general. It is confusing to those clinicians who perform therapy, more confusing to those who aspire to perform therapy, and even more confusing to consumers seeking therapy. It is clear that education is necessary, as well as continued discussion and research as to what makes for effective psychotherapy. Until then, to paraphrase Santayana, "Those who do not learn from the past are condemned to repeat it," with the historical proviso that in the case of the hundreds of psychotherapies mentioned that their seems a repetition compulsion to continually create therapies with new names that, upon scrutiny, many look very much like those they claim to replace. ■

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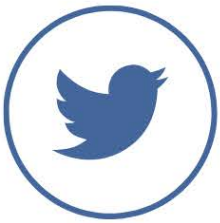

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The resources and information on this page – **https://www.samhsa.gov/find-help/988** – are designed to help states, territories, tribes, mental health and substance use disorder professionals, and others looking for information on understanding the background, history, funding opportunities, and implementation resources for strengthening suicide prevention and mental health crisis services.

AACAP Policy Statement on Vaping and Electronic Cigarettes

Youth vaping is an emerging epidemic, with 1 in 10 (2.5 million) U.S. middle and high school students currently vaping. Vaping is the act of inhaling vapors produced from a liquid solution aerosolized by an electronic device such as an electronic cigarette (e-cig) or vape pen. The liquid solution used in vaping devices typically contains a psychoactive drug such as nicotine or Δ9-tetrahydrocannabinol (Δ9-THC), the primary addictive components of tobacco and cannabis, respectively. Vaping of other cannabinoids including cannabidiol (CBD) and legal Δ9-THC analogues (e.g., Δ8-THC) is also increasing in popularity. Vaping results in higher blood serum concentrations of THC and nicotine compared to smoking combustible forms of cannabis or tobacco products. As a result of this higher exposure, regular vaping of THC and nicotine among youth can lead to vaping-related cannabis and tobacco use disorders characterized by the development of tolerance, habituation, loss-of-control over vaping behaviors, and experience of withdrawal symptoms upon cessation.

Nicotine exposure during adolescence is associated with behavioral and neurochemical changes along with continued engagement in tobacco and other drug use. Further, tobacco-naïve youth are initiating nicotine exposure through vaping. Youth who vape are also more likely to smoke cigarettes. Cannabis use, and particularly high-potency THC use, is associated with development of cannabis use disorder and the misuse of other substances. Problems associated with heavy cannabis use during adolescence include worsening mental health with increased risk of suicide, cognitive dysfunction, altered neurodevelopment, decreased school completion, and other health and socioeconomic consequences.

Not all harms related to vaping are the result of nicotine or THC exposure. Recent studies have found an array of environmental toxins within the vapors of commonly used e-cig brands including heavy metals, reactive oxygen species, aldehydes, and carbonyls. These toxins often result from chemical reactions between the heating elements, fluid components, and chemical flavoring agents. Specific carcinogens identified in the vapors include formaldehyde, acetaldehyde, and nitrosamines. Vaping may result in increased risk of toxicity and pulmonary injury, including e-cigarette or vaping associated lung injury (EVALI), as well as mechanical burns.

Youth are being increasingly targeted through direct advertisements, peer marketing, social media, and pop culture. Products are also designed for easy concealment as everyday items (e.g., highlighter, USB flash drive). Flavor additives have been shown to be the most important factor in youth initiation of vaping. While the safety of electronic vaping devices has not been scientifically established, e-cigs have been portrayed as less hazardous than conventional tobacco or combustible cannabis products. Manufacturers have also advertised e-cigs as tobacco cessation treatments. In fact, online interest in vaping has surpassed conventional tobacco cessation treatment among individuals who want to quit smoking. These factors contribute to decreased perceived harm of vaping. Though many states have enacted age restrictions, vaping devices and liquid cartridges remain easily accessible to underage youth through online purchasing and within local communities and peer groups.

To protect youth from behavioral and physical harms associated with vaping, the American Academy of Child and Adolescent Psychiatry:

- **Recommends that clinicians screen all youth for vaping behaviors and for vaping as a method for consumption of nicotine and cannabinoids, following Screening, Brief Intervention, and Referral to Treatment (SBIRT) guidelines, and promote the use of evidence-based treatments for vaping cessation across all youth health care settings.**
- **Encourages researchers to prioritize the development of primary and secondary prevention strategies for youth at risk of vaping and to develop and promote evidence-based treatments for youth who develop vaping-related cannabis and tobacco use disorders.**

AACAP Policy Statement on Vaping and Electronic Cigarettes

- **Supports state and federal policies that restrict youth access to vaping devices, flavor additives, and direct advertising that target youth and are associated with increased uptake of vaping among youth.**
- **Supports state and federal regulation of e-cigarettes, electronic vaping devices, liquid cartridges, and any product containing nicotine or cannabinoids.**
- **Supports policies that identify and address barriers to substance use disorder treatment for youth, including stigma associated with seeking treatment.** ■

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