

News

RCCAP

Regional Council of Child/Adolescent Psychiatry for
Eastern Pennsylvania and South Jersey



Randall Gurak, MD



Laurel Weaver, MD, PhD

LEADERSHIP MESSAGE

Our Eastern Pennsylvania and Southern New Jersey Chapter has a long and distinguished history of excellent leaders. From our very first Executive Committee to our present, they have worked diligently on the issues facing Child Psychiatrists and the families we serve. Many have taken active roles nationally in AACAP in the Assembly, chairing committees and assuming leadership positions as officers in AACAP. Also, we have been active in the APA and, at one time, our RCCAP, included the presidents of our three APA district branches in PA, NJ and DE.

Our current RCCAP's Executive Committee is a group of dedicated individuals who meet monthly to chart the course in the achievement of our field.

We have an active Program Committee, which plans our annual educational activities, including:

1. Career Day where our residents and early career child psychiatrists can hear about all the

EDITOR'S MESSAGE

G. Pirooz Sholevar

"If you see a unicorn, you should report it"



The inaugural issue of the newsletter of Regional Council is highly exciting.

The council published a newsletter for four years before, it ceased publication. We intent to make the new newsletter very lively by enhanced enthusiasm in general membership. The leadership of the Council is already very excited and strongly supportive of the newsletter. A few crucial leaders are very committed to make the newsletter thriving and of high quality.

The newsletter is intended to provide a unique forum for the membership to further engage with, learn from and express their views to each other. The ultimate dialogue among the membership will increase their knowledge of the field, each other's interests and work and combine their assets, visions and achievements to enhance their pride in themselves and the field.

- 1) The newsletter will be published 3 times a year, in early September, early December and on June 1st.

The December issue will be a double issue and half of it will cover the highlights of the annual

options available and speak with multiple psychiatrists who provide firsthand information about employment opportunities.

2. Child & Adolescent Psychiatry Therapy and Psychopharmacology Conference in which we bring in national experts to give us the latest developments on a topic in our field.
3. Herman Staples Dinner, which is our annual celebration of the past year for our awardees and graduating residents followed by an informative lecture from either our current AACAP President or a prominent national leader.

This year has been a challenge as with all organizations during the COVID crisis. We have held our programs and Executive Committee meetings remotely. We have been discussing the effects of systemic racism in our profession and in society and its impact on the families we serve. We have also examined the impact of the COVID-19 pandemic and how it has affected our patients and our practice.

In our inaugural newsletter we welcome you to reacquaint yourselves with our Chapter. The Newsletter will help all our members stay informed as to what our ROCAP is planning and how you can participate. It will also be a vehicle to keep us abreast of recent developments in our field locally and nationally and highlight the trends in our ever changing knowledge in Child and Adolescent Psychiatry.

We welcome your input and feedback. We look forward to seeing you at our events, even if it is remotely, and we hope you will consider joining our leadership team.



Leadership. Getty Images, Inc., 12 Feb 2019, <https://www.inc.com/anne-sugar/ask-these-2-simple-questions-to-grow-as-a-leader.html>.

meeting of AACAP. The local presenters are encouraged to submit a summary of their papers to this issue.

- 2) The newsletter content should be readable, “appetizing” and informative. The language should invite reading. It should play to the interests, strengths and needs of the total membership. It should enhance the individual and professional identity by incorporating the richness of our exciting activities.
- 3) The news comes in different forms and shapes. There are individual news such as Anthony Rostain, MD being appointed as the Chair of Department of Psychiatry at Cooper Medical School and Yolanda Graham, MD having been appointed the Chief Medical Officer and Senior Vice-president for Devereux Foundation. She oversees about fifty (50) child psychiatrists nationally in nine different states.
- 4) The clinical activity of the Regional Child Psychiatrists at times reaches a reportable level and can inform the total group. As one of my mentors, President Phillips used to say, “If you see a unicorn, you have to report it”. I believe there are a few unicorns among us who are reportable regionally and nationally. This particularly relates to clinical area in many subdivisions of child, adolescent and family psychiatry.
The Crisis Centers at Belmont Hospital and Children’s Hospital of Philadelphia have become recognizable clinical units regionally.
- 5) There are significant scientific treasures on the national level and we should learn more about them and contribute to them. The areas of irritability, attachment, disruptive mood dysregulation and Autistic Spectrum Disorder, their specialized treatment and prognostic

EDITOR'S MESSAGE CONTINUE

trajectory are focus of productive investigation and scientific conclusions. Knowing about classical autism is not sufficiently informative in the treatment of the people with ASD as children, who have subsequently acquired language, were able to graduate regular schools but act differently in treatment and in their everyday life.

- 6) We envision the newsletter to have several sections/departments which include: announcements, clinical column/section, science section/corner, membership activities column/section, journal club column/section and notable national news.

We are looking forward to any member interested to volunteer to chair in any of the above sections. The journal club section should be of interest to people who are running a journal club in the training programs or are responsive and interested readers of articles in the orange journal and in green journal which is publishing increasingly more significant child psychiatric papers.

- 7) The letters to the editor will make membership respond to the articles with agreeable, complementary or objectionate comments to the contents of the different sections of the newsletter. This will help us to have an informed and specific dialogue. I find the letters to the Editor in the Green Journal, Orange Journal and New York review of books as exceptionally exciting and clarifying columns.
- a) The Editorial Board of the Journal includes two deputy editors namely **Rao Gogineni** and **Randy Gurak**. The president is an exoficio of the Editorial Board. Two other members are considering joining the Board as deputy

directors. We plan to develop an Editorial Board of interested: a) readers and b) writers.

If you have a **writer's block**, we will cure it at no cost. The editors are looking forward to hear your ideas as how to make the journal exciting reading, meaningful, informative and an effective communication vehicle among the members.

- 8) For members who prefer to receive a hard copy of the journal rather than its electronic version, please advise and we will find a solution to your preference.
- 9) It is significant that Pennsylvania Board of Medical Examiners has designated the subject of physician burnout as one of the three major areas of education and examination for licensing physicians. Simultaneously, there was a lead article in the Green Journal by Richard Summer who is one of our local colleagues at the University of Pennsylvania examining the burnout in psychiatrists with some amazingly high percentages (which I believe is based on a very non representative sample). However, the two events frame the issue of the "burnouts" and the opposite of that which is to be "fired up" about your professional, clinical and teaching activities. One goal of the newsletter is to identify the burnout in ourselves and colleagues, and counter it with setting a fire to it and get "fired up" as a group. The newsletter can be the tool to set this fire.

Alexander the Great's mother claimed that her womb was "touched by the fire" when she was pregnant with him.

With best wishes for a vaccinated New Year,

G. Pirooz Sholevar, MD – Editor
Rao Gogineni, MD – Deputy Editor
Randy Gurak, MD – Deputy Editor



Marilyn B Benoit, MD, SHSA, LFAACAP -AACAP Past President 2001-2003

THE LEADERSHIP JOURNEY

I am excited to contribute to the inaugural issue of “NEWS: RCCAP Eastern Pennsylvania and South Jersey” I have been pleased to be a member of your council for the past few years and meet with many of you personally and work with a few of your members at Devereux Foundation when I was the Vice-president and Chief Medical Officer. I do hope that you have all been staying well during this prolonged COVID-19 pandemic. I admire how the scientific programs have been creative in continuing to provide learning opportunities and how you have adapted to this new environment. Our services are needed more than ever during this crisis. Pivoting to meet these increasing needs has required leadership at all levels and in varying challenging circumstances. In my presentation I mentioned that leadership is not necessarily a position with a title....it is action. And there are myriad opportunities around us.

My own leadership behavior was modeled after my parents. My father rose through the ranks as a teacher to become a Superintendent of Schools. My mother, a homemaker, assumed leadership roles in her community while raising nine children. She formed a Birthday Club, a Christmas caroling choir, single handedly took dozens of kids from the community on day long picnics, held jumble sales to raise money for social causes, and had us prepare and distribute flyers during political elections. At about 8 years old I began holding classes for the pre-school kids with the ever-present blackboard and chalk at our home. Thus began my love of teaching. Professionally, providing training to medical students, residents and fellows has been a highlight of my career. Providing leadership in designing a curriculum and syllabus, recruiting lecturers and monitoring development and performance have been tremendously gratifying. I wanted two things in my adult life: to be a mother and to be a doctor. At age seventeen I had written that I wanted to be a psychiatrist because I was totally enamored with the brain and its capacities as the command-and-control center of the amazing human body.

I deferred medical school for two years after getting married upon College graduation and having my first child. She was two years old when I entered medical school. My son was born in my 4th year of medical school. My good fortune was that Georgetown University had a small day care center where I took my daughter and could visit her during my medical school breaks. I also was fortunate that Judith

Rapaport, MD, past Chief of Child Psychiatry at NIMH, was launching her research career and I was able to have three months at home with my son while participating in her research project on ADHD and use of medications. I had taken the initiative to seek her out and ask if she would consider me for that research position as a fourth-year elective in Psychiatry. That launched me professionally with my first peer reviewed journal article and my first national presentation at AACAP.

I completed my general and child & adolescent psychiatry training at Georgetown in a four-year program. Since I had children I was not happy about having a Saturday morning seminar. Here was a leadership opportunity. I surveyed my colleagues to inquire if they would trade adding an extra hour one day during the week to free up Saturday morning. Once they agreed, I approached the professor and asked if he would consider. Everyone preferred that arrangement. Another example of my challenging the status quo was within AACAP, where 35 years ago, still an early career psychiatrist and an AACAP Committee member, I approached Dr. Richard Cohen, then President, and said to him that it troubled me that as a child serving medical association we did not have a committee that addressed issues of child abuse. On the spot, in the hallway, he agreed with me and said "you're right Marilyn. You will be the Chair. Go start one!" And one year later we launched AACAP's Child Abuse Committee in Washington, DC. at the annual meeting. Thirty-five years later it has been re-named the Child Maltreatment & Violence Committee and I am honored that there is now an endowed Marilyn B Benoit MD Child Maltreatment Mentorship Award that provides funding annually for a fellow or early career child psychiatrist to complete a relevant project over a four-month period. My AACAP involvement began as a fellow when our Training Director encouraged us to join. I have served on several committees over the years at AACAP. My other involvement at AACAP was submitting proposals for the annual meeting and presenting with colleagues. I have also participated in ongoing mentorship programs, and provided leadership for the minority medical students programs when they were first introduced about two decades ago. Eventually I was nominated for a Councillor-at-large position and won. Subsequently I was elected to the position of Secretary and then as President.

Taking initiative is also important in leadership. For my AACAP Presidential Initiative, I spearheaded, in collaboration with the Child Welfare League of America, a national coalition of 70 stakeholders in foster care and together worked on improving the total care and management of foster children in America. In the late 1980's hospitals were taken over by MBAs because physicians had demonstrated that they lacked the skills to manage the business of running hospitals. The physicians at the academic hospital where I worked were extremely unhappy because the clinical work was being compromised by business decisions. I am not a complainer. I soon decided that I would enter the graduate school of business at the university where I had free tuition and earned a graduate business degree as a **Specialist in Health Services Administration**, focusing on healthcare policy and management. It took me four years and I loved the new knowledge, and with a promotion to Vice President of the Child Psychiatry, I could apply my administrative and fiscal skills to running the department. I loved this leadership opportunity and thrived, later assuming the role of Interim Chair of the department and

Chief of Service which put me in an upper executive management position at the hospital, allowing me to participate in Board meetings.

Other senior leadership positions have included being President of AACAP (2001-2003), Medical Director and Executive Director of Devereux Children's Center in Washington, DC; Corporate Senior Vice President, Chief Medical Officer and Chief Clinical Officer of Devereux Advanced Behavioral Health. I embrace Servant Leadership as my leadership style, focusing on providing employees with the resources and tools they need to succeed, as well as providing educational opportunities for each person's professional development.

In conclusion, I consider myself fortunate to have had amazing mentors and facilitators along my career journey, and to have had the wisdom to take advantage of the opportunities that presented themselves. Throughout, I have always made time for my supportive family and friends and taken time out to have exuberant fun! My advice to you is:

- Know thyself: your passions, your strengths and challenges. Then, decide what is best for you.
- Seek mentorship that works for you.
- Be open to leadership opportunities in small ways and big ways.
- Don't be afraid to challenge the status quo. Speak up!
- Be kind and generous of spirit.
- Be humble and embrace Servant leadership. Take care of yourself and have fun!



HEROISM

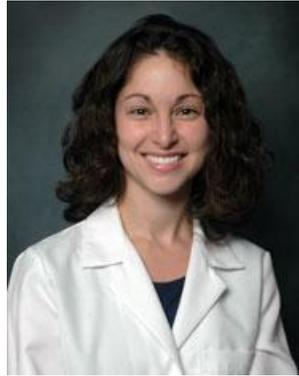
It is not enough to do your best; sometimes you have to do what is required.

-Winston Churchill

Neurodevelopmental Disorders: Families during the COVID 19



Anthony Rostain, MD



Nicole Leopardi, MD



Rama Rao Gogineni, MD

COVID 19 is creating a mental health crisis among children and youth around the globe. The pandemic has created the largest disruption of education systems in history, effecting nearly 1.6 billion learners in more than 190 countries and all continents. The pandemic has a unique impact on Children, Adolescents and adults struggling with Neurodevelopmental Disorders and their Families. The COVID 19 pandemic may worsen the existing mental health problems of ADHD, Autism, and other neurodevelopment disorders. The pandemic is raising fears, and causing clinginess, distraction, irritability, anxiety, depression, lethargy, impaired social interaction, and reduced appetite. Adolescents are at higher risk for depression, anxiety, distress, low self esteem, substance use disorder, and suicide. Mental health consequences of the pandemic include adjustment disorders, reactions to social isolation, reactions to family and family events, violence against women

and children. Major challenges are being experienced by those struggling with attention deficit hyperactivity disorder, autistic spectrum disorders, medical complications, posttraumatic stress disorder, and other conditions.

Reactions to family and family events

Parents experience much turmoil due to fear and anxiety about COVID-19. They are likely to be burdened by the need to care for the children and perhaps their parents. Having to cope with their children's demands and needs may cause parents to experience intense distress, anxiety, and depression. Children tend to react to their parents, stress reactions which can exaggerate their own distress.

ADHD children, particularly adolescents, are vulnerable to the distress caused by the pandemic and physical/ social-distancing measures. They may display increased behavioral problems because of their executive

functioning difficulties, impulsivity, and risk taking. .Lessened structure, increased distractions at home, increased demands on overburdened parent contribute to increased need to structure the executive function, and increased demandiness. As a result of COVID-19, parents are doing the work previously shared by a team of trained clinicians, special education teacher, parent support specialist. There's no expectation that any parent should be able to take on any of the above roles, let alone master them.

Case example

A mother of a 15-year-old male who is experiencing an increase in ADHD and aggressive symptoms states: "I am doing okay. I know this will be over. But I am worried about my son, about him going to jail, ending up living on streets or getting killed." While this mother tries to comfort herself about the situation getting better, she describes significant worries about her son's behavior.

Autistic spectrum disorder

Children with autism spectrum disorder (ASD) often experience changing routines as a major challenge. For that reason, the need for adaptation during COVID-19 pandemic may have brought major problems to families with children with this pathology. Thom and McDougal [7] observe that as most ASD children are not able to receive support services including special education, behavioral therapy, occupational therapy, speech services, and individual aides through school during the pandemic. Majority of parents of ASD children reported a negative impact in emotion management, higher mean scores of anxiety levels in themselves than in their children. Parents are finding themselves simultaneously expected to play the role of parent, special education teacher, and individual aide, all the while having to provide care for other children and juggling work from other responsibilities. Aggressive and self injurious behaviors in ASD children may also increase during this time of fear and uncertainty.

Case example

A 17 year old teenager male with a history of high functioning ASD, oppositional/defiant disorder, and violent/aggressive outbursts was admitted to the hospital for exacerbation of the same with limited access to his usual psych supports because of COVID. He required crisis placement and changes in medications.

Positive outcomes during the early stages of the pandemic

US-based surveys of about 8,000 SPARK parents or guardians and 600 autistic adults in March–April 2020 reveal some positive experiences coping with the pandemic, despite high stress and disruption: positive use of time, extra family time and time to pursue hobbies, limiting social media and news, exploration of calming activities, slower pace for learning, and adaptation to virtual social connection, learning, and healthcare. Many families informed that the families staying home enabled them in rebuilding relationships, working through some attachment, communication, post trauma/stress related relationships. Children and parents found more time and opportunities in engaging with more family time for activities. There are other silver linings that individuals and families are discovering, all of which suggest that resiliency skills can make a major difference in the way people are experiencing the pandemic.

Conclusions and Recommendations

1. See and remain in close touch with your family members
2. Get enough sleep to mitigate mental health difficulties under stressful circumstances
3. Proactively manage stress threshold – Try to lay a solid foundation for your mental health and well being by prioritizing sleep,

eating well, and exercising regularly

4. Practice mindfulness: Be compassionate with yourself and with others, maintain connections and manage uncertainty by focusing on the present moment

5. Parents: Establish and maintain daily routines, encourage virtual social interaction, and develop strategies for nurturing resilience in children and adolescents. Make sure to address their fears and concerns, play collaborative games to alleviate loneliness, encourage activities that promote physical activity, play or listen to music, and practice relaxation methods. Model a positive psychological attitude to reduce stress and divert children’s attention in productive and positive directions.

6. The rapid expansion in the use of telehealth platforms can have a positive impact on both care and research. It can help to address key priorities for the NDD communities including long waitlists for assessment and care, access to services in remote locations, and restricted hours of service. It behooves us to use this crisis as an opportunity to foster resilience not only for a given individual or their family, but also the system: to drive friendly changes in healthcare, social systems, and the broader socio-ecological contexts.



Deadly Sins of Well-Meaning Child Psychiatrist That Perpetuate Racism (Part 1)

By: J. Corey Williams, MD, MA

The insurrection attempt on January 6th at the US Capital has once again catalyzed a national discourse into the culture of white supremacy that permeates this society. The mob violence laid bare their white privilege—advantages possessed by white people— for the world to see. The restraint, gentleness, and passivity largely exhibited by law enforcement towards the insurrectionists stood in sharp contrast to aggressiveness, brutality, and hyper-militaristic approaches to Black protesters in the past. As someone involved in activism for Black Americans, having been dispersed by tanks and teargas in residential neighborhoods, I felt that horrific scene at the Capital was an act of blatant hypocrisy. This illustration of embodied white privilege should compel us to consider all the ways in which everyday people enforce, enact, and perpetuate a system of racism that makes white privilege possible.

While racism is most aptly described as an institution— policies, practices, and norms that differentially distribute resources, opportunities, and power by race— we must acknowledge that institutional racism is *upheld* and *enforced* by individual persons on a daily basis. The racist policies and the individual actions of people are mutually reinforcing. In other words, *individuals* carry out the policies, and thus, individuals are co-responsible for racial violence. In the healthcare or mental health context, racism and white privilege are baked into the healthcare institutions and carried out by individual practitioners every day.

There is a growing awareness among well-meaning psychiatrists around the ways in which routine clinical practices are implicated in a system of racism. In this article, I would like to demystify some of the major ways that psychiatrists participate, enact, and are complicit in systemic racism. Of course, this is not meant to be an exhaustive list. Rather, it is meant to point out the subtle, insidious, and routine ways in which clinicians participate in a system of racism. Ultimately, these types of lists are meant to spur self-reflection, to nudge the reader into taking an antiracist approach to their professional practice and personal lives. An antiracist approach acknowledges that racism is pervasive and commands the practitioner to take vigilant and proactive steps to root out racism.

- 1. Assuming that because you are a physician or healthcare provider; you cannot be racist.** Identifying as a healthcare provider can dangerously serve as a false exculpatory veil of responsibility. Being in a healthcare or helping profession does not protect anyone from racist beliefs and behaviors. Arguably, medical providers have an outsized responsibility for the promulgation of racism. Historically, physicians, in particular, have provided the cultural authority and legitimacy to white supremacist ideology allowing it to take root in the US. In addition, physicians have participated directly in violence towards BIPOC (Black, Indigenous, and

People of Color) through participation in the slave trade and have continued exploitative experimentation and research practices throughout the last century, for example.

Furthermore, health care professionals should not assume that proximity to human experience and pain makes them more sensitive and understanding to that suffering. On the contrary, if a physician is not engaged in regular self-examination and reflection on anti-racism principles, being proximate to human suffering can cause indifference and even resentment towards those who are suffering. Taking an antiracist stance begins with the admission that we all hold biases, regardless of profession, and must take active steps to unlearn them and/or mitigate the impact of those biases.

- 2. Practicing race-based diagnosis.** The psychiatry literature is replete with over-diagnosis and under-diagnosis of certain disorders for BIPOC. For example, a robust body of literature illustrates that psychiatrists overdiagnose psychotic disorders in BIPOC patients and under-diagnose mood disorders like depression. When it comes to the assessment of BIPOC patients, certain aspects of the diagnostic criteria tend to become more salient that operate to map onto racial stereotypes or devaluation of the patients. For example, in one study of conduct disorder diagnosis, the psychiatrists at a residential treatment program disproportionately diagnosed conduct disorders in the Black and Hispanic children compared to the white children (Cameron & Guterman, 2007). This was largely significantly overestimated the levels of aggressiveness and externalizing behaviors for Black and Hispanic children compared to the actual level (as measured by the CBCL). The aggression criteria were overemphasized for the Black and Hispanic children, which align with the deeply embedded stereotypes about Black and Hispanic as being violent that exist in the broader culture.
- 3. Making assumptions about culture based on racial identity.** I have seen psychiatrists make harmful assumptions about a family because they think they “know” the culture. There is a spectrum of varying degrees to which a family can be orientated towards that own culture and/or the dominant culture. We should never assume that we know a family’s culture based on their racial phenotype or self-identification. We should never assume that we are finished learning about cultures, vulnerable populations, and marginalized groups and commit to lifelong learning (i.e. cultural humility). We should never be afraid to ask patients to teach us about their unique cultures so that we can better understand their unique needs. We should be incorporating assessment tools like the Cultural Formulation Interview (CFI) or the Structural Vulnerability Assessment (SVA) into our routine practice habits. In many cases, when a nuanced cultural perspective is taken with a particular family, the diagnosis and treatment will be fundamentally changed (Kirmayer et al., 2003). Asking explicitly about a person’s culturally informed beliefs will better equip psychiatry to deliver culturally responsive care.

The power of white supremacy is in its insidious and assumed normality; therefore, it may takes vigilance and proactiveness to recognize that you have both explicit and implicit bias as well as participate in white

supremacist culture. Make an action plan for how you will mitigate your bias in interactions for historically oppressed groups. Perhaps you might audit your prescribing habits periodically, seek extra layers of supervision, or form a support and reflection group at your institution.

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Heart of kids holding hands. Digital Image. *Nationwide Children's*. 1 June 2020, <https://www.nationwidechildrens.org/family-resources-education/700childrens/2020/06/how-to-talk-to-your-kids-about-racism>.

Journal Club

Prospective Prediction of First onset of Non-Suicidal Self Injury (NSSI) in Adolescent Girls

Molly Gromatsky et al – JAACA Psychiatry – September – 2020, Vol 59, pp. 1049-1056

The participants (all the deputy editors, members of Executive Committee and others nobilities and members of the council are encouraged to write a 2 paragraph discussion to this paper).

Abstract:

Pirooz Sholevar, MD

A number of cross-sectional and five longitudinal studies have identified behavioral factors of disinhibition and negative affectivity as strongly correlated with NSSI. The personality/clinical characteristics of rumination, self-criticism, avoidance, neuroticism and low consciousness are other correlating traits. The parental correlates are disruptive behavior (such as explosiveness and ADHD), substance use, depression and anxiety.

The present longitudinal study measures all the above characteristics at baseline and in four waves of follow up, nine months apart. The participants are a group of 462 adolescents girls with no current or previous history of NSSI. The age of the girls were from 13 to 15 (mean age: 14.39 years), and from nonclinical, volunteer community population. A number of easy to use tests have been administered for specific trait evaluations in addition to Kiddie-SAD “disinhibition” is defined as a tendency to act with comprised ability to delay action in order to plan, but to seek excitement and adventure. “Negative affectivity” refers to experiencing strong negative affects such as dysphoria, dysthymia, anxiety or emotional reactivity to events with negative affects. NSSI provides a relief from negative affectivity and rumination.

Forty two (42) out of 462 adolescents (9.1%) developed NSSI within the course of 3 years study. The majority developed NSSI in 13.7 months into the study, at the (mean) age of 15.34; half of them with the frequency of 10 incidents and others with lower than 10 frequency. The most common method was self cutting and 50% experienced pain during the act. They acted on their urge within an hour and denied the desire to stop their action.

The study confirmed the investigators hypothesis that the clinical traits in the children and parents predictably played a decisive role in the genesis of NSSI. This knowledge can be used to prevent the emergence of NSSI, make the treatment more effective and intervene to alter the progression of NSSI into subsequent suicidality, or its continuation into adulthood because 50% of NSSI(s) continues into adulthood life.

Comment by Pirooz Sholevar, MD:

This is a significant, well designed study with sound methodology which addresses a common clinical syndrome with fair likelihood of leading to future suicidality and persistence into adulthood. The correlating clinical variables and traits have been well established in cross-sectional studies and five longitudinal investigations with limited scope. It lends itself easily to clinical application and allows the clinician to focus on the significant correlating variables namely disinhibition and negative affectivity. It also addresses other correlating clinic traits in the form of rumination/self-criticism, avoidance, neurotism and low consciousness. The parental characteristics of disruptive behavior (explosiveness or ADHD), substance use, depression and anxiety are included.

Disinhibition is defined as low ability to delay action in order to plan, but to seek excitement and adventure. "Negative affectivity" refers to experiencing strong negative affects such as dysphoria or responding with emotional reactivity in the form of dysthymia or anxiety.

Patients with NSSI are triggered into negative affectivity but on average do not harm themselves from an hour, while avoiding to talk about their thoughts and feeding due to formidable avoidance which defeats even most expert clinicians. The clinicians may resort to a no self-harm "contract" which is no match for the six clinical traits in operation. Knowing of the strength of avoidance mechanism, it should be designated as a Herculean goal to accomplish through a series of successive, small steps in the hour with full partnership with the patient.

The six de-stabilizing traits studied in this investigation have broad applicability beyond NSSI. They can be applied productively to suicidality, DMDD, eating disorder (bulimia) and ASD. It would allow abroad and comprehensive interventions rather than being trapped by the symptoms, which have entrapped the patient in the first place.

Consciousness emerges as a variable of NSSI although it is not defined in the paper. Using common definition of this variable, conscious has 3 components of: a) awareness, b) attention and c) self reference. It is very similar to the "sense of self" in "ego psychology" described by John Frosh forty years ago. It means the person is not aware and does not attend to the other person, the situation, surrounding and more importantly himself. She responds to the teacher in the classroom asking for her homework as if the teacher is a bully in the parking lot and responds to the teacher by physically threatening her in self-defense. This concept lends to well-defined, targeted interventions with my patients with decisive impact.



RCCAP

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PLEASE VOLUNTEER

To organize one of the following subgroups of RCCAP Psychiatrists at:

- 1- Inpatient Services
- 2- Outpatient Services
- 3- Crisis Centers
- 4- Psychoanalytic C+A Psych
- 5- Hispanic Children
- 6- Substance Use
- 7- Academia
- 8- Residential Treatment
- 9- Day Treatment Centers

Writer's Block Treatment Center

Just bring your pen, paper, keyboard and of course your mind!

The treatment cost is covered by AACAP and most reputable insurance companies.



Yolanda Graham, MD

*Senior Vice President, Chief Medical Officer
and Chief Clinical Officer
Devereux Foundation*

Yolanda Graham, M.D. is the Senior Vice President, Chief Medical Officer and Chief Clinical Officer at Devereux Advanced Behavioral Health (DABH). She is also the director of the Institute of Clinical and Research, Training and Research and the Chair of Devereux Institutional Review Board (IRB). As he Chief Medical and Clinical Officer, she oversees approximately fifty (50) child/adolescent psychiatrists, 200 nurses and 300 clinicians. With a passion for helping youth, Dr. Graham has dedicated her career to working with the most traumatized and marginalized youth in our society, implementing best practices to help them heal within a residential treatment setting. She served as the medical director at two residential facilities in Georgia—Inner Harbour (now Youth Villages) for 12 years and Devereux Advanced Behavioral Health (Georgia) for eight years, prior to being promoted to Executive Director of Mental Health Services at Devereux in 2016 and Chief Clinical/Chief Medical Officer in 2018.

Dr. Graham is double Board certified in general psychiatry and child and adolescent psychiatry. She completed her undergraduate studies at Cornell University and received her medical degree from the State University of New York at Buffalo. At Emory University, Dr. Graham completed her residency, child and adolescent fellowship, and a two-year research fellowship sponsored by the American Psychiatric Association. Her research under the mentorship of Dr. Charles Nemeroff focused on the neurobiology of trauma and the neurobiological impact of maternal depression on infant development. Dr. Graham served as an Adjunct Clinical Professor at Morehouse School of Medicine and Emory University for many years, and is a past president of the Georgia Council on Child and Adolescent Psychiatry and the Georgia Psychiatric Physicians Association.

Dr. Graham is an expert in psychotropic medication management, behavioral management, childhood sexual exploitation and trauma. She is a national speaker, keynote speaker, consultant and advisor. She specialized in residential treatment after years in academia, a successful private practice, and working as a consultant with the Department of Juvenile Justice to develop gender responsive programming. She has extensive experience on child sex trafficking which culminated in the development of a novel program. The city felt obligated to respond, however there was very little information available regarding the treatment needs of this population. Dr. Graham was approached by the Juvenile Justice Fund to develop a clinical treatment program for Angela's House, the first safe house for sexually exploited children in the southeast region financially supported by Juvenile Justice Fund.

Born in Georgia, Dr. Graham lives in Philadelphia, Pennsylvania with her wife, 13-year-old son and their Golden Doodle "Sippy." She also has a 31-year-old daughter who lives in Atlanta.