

PRESIDENT'S COLUMN

By Benjamin Schneider, M.D., SCSCAP President



I am truly honored to have served this year as the President of SCSCAP. It is an inspiring group with an awesome mission. Even during the throws of the continued pandemic, through all the times we have been asked to “pivot” and adjust, our field has experienced no

“lull.” And pivot we have. Emergency Department volumes for psychiatric patients have surged. Inpatient units remained full or understaffed. And, in a striking display of the continued impact of COVID on child psychiatry trainees, some first-year fellows have shared that they have not yet seen an outpatient in person during the entirety of their training – both residency and fellowship.

I know I am not alone in this. Through all the hardship, the most difficult aspect of this year has been the loss of a friend and mentor to so many of us in this field. On December 31st, Dr. Mark DeAntonio passed away. Many of our readers will know Mark personally – either through some connection to UCLA or AACAP. To say he is legendary is an understatement and I am hard-pressed to imagine someone who has had such an impact on so many lives – from the patients he treated to the psychiatrists he trained.

Just before he died, over 50 colleagues and current and past students sent video tributes to be shared with Mark and his family to express their love and gratitude. In addition to the usual newsletter updates, you will also find a tribute reprinted about Mark’s remarkable life, passionate work, and commitment to the field we all hold dear. *Please see page 12 for more tributes.*

Mark DeAntonio, MD

November 17, 1954 – December 31, 2021

It is with deep sadness that the Child and Adolescent Division and Department of Psychiatry and Biobehavioral Sciences announce the passing of Mark DeAntonio, MD, Professor of Clinical Psychiatry, at the age of 67 after an extended illness fought with great courage. Dr. DeAntonio continued working up until 2 weeks before his death. A beloved teacher, master clinician, humanitarian, role model and colleague, he will be sorely missed.

Dr. DeAntonio was a California native, growing up in the San Fernando Valley as the son of Carlo DeAntonio, MD, the 1st child psychiatrist to practice in the Valley, and his mother Madeline, a psychiatric social worker. As an undergraduate he attended UCLA and, following a foray into the emerging Venice art and music scene, graduated from UC Santa Cruz with a degree in molecular biology.

Mark received his M.D. from Stanford University School of Medicine in 1982—later he was profiled in a compilation of “famous 40” graduates from Stanford Medical School. Dr. DeAntonio went on to an internship and residency in general psychiatry at Yale. Despite being heavily wooed to stay, he returned West to complete his training in child and adolescent psychiatry at the UCLA Neuropsychiatric Institute and Hospital, where he was awarded the Gertrude Rogers Greenblatt Fellow Award for the most compassionate and exemplary clinical care demonstrated by a graduating child psychiatry fellow. Subsequently Mark joined the faculty at UCLA in 1988, and UCLA remained his only academic home for 33 years despite being recruited by multiple programs. Soon after his faculty appointment he became the Director of Adolescent Inpatient Psychiatry and later the overall Director of Inpatient Child and Adolescent Psychiatry at the UCLA-Resnick Neuropsychiatric Hospital, a position he retained until his passing.

Dr. DeAntonio had a passion to provide care for the most severely mentally ill and vulnerable youth, especially those with developmental disabilities, who often might have gone unheard or neglected. During his career Dr. DeAntonio rose to the level of Professor of Clinical Psychiatry and received numerous accolades and awards for his teaching and clinical expertise, including the Outstanding Achievement Award in 2021 from the Southern California Psychiatric Society. Less well known was Dr. DeAntonio's support for over 20 years as a consultant to the UCLA Pediatric HIV/AIDS Program, chairing a national child psychiatry committee on HIV Issues, and leading the Media Theatre portion of national child psychiatry meetings. Dr. DeAntonio took great pleasure serving as a board member for the Southern California Health and Rehabilitation Programs (SCHARP), a community based mental health agency in south Los Angeles and in his work as a medical missionary providing care to indigenous peoples in the Andes of Peru, where he made annual visits, sometimes accompanied by trainees, until interrupted by the COVID-19 pandemic.

As news of his declining health recently circulated, nearly 3 hours of individual video testimonials were received from former trainees and colleagues from around the United States, expressing their gratitude and admiration for his profound impact on their careers as an educator and role model, and their admiration for his obvious devotion to his family. Mark will also be remembered for his enjoyment of hosting dinners in his lovely home with his wife Polly for visiting speakers, faculty, and trainees and for his many interests—he told spellbinding stories of the early punk rock scene (including his own musical exploits) and had a passion for music and film, the outdoors of the Western US, astronomy, and animals. He had overflowing pride in the accomplishments of his wife and their two children. His colleagues and the Department mourn his passing but celebrate his enormous contributions to the field of Child and Adolescent Psychiatry and to the UCLA training program that he loved.

Dr. DeAntonio is survived by his mother Madeline DeAntonio, his wife Polly Estabrook, their son Jasper DeAntonio (spouse Abigail Rae Kirchman and grandchild Juniper Marie), their daughter Charlotte DeAntonio, his



brothers Carlo DeAntonio, MD, and Thomas DeAntonio, PhD, and his sister Luisa T. Buchman, PhD.

The family requests that any contributions in his honor be directed to UCLA c/o "UC Regents—Mark DeAntonio Memorial Fund in Child Psychiatry", Semel Institute, 760 Westwood Plaza, Rm 48-240, Los Angeles CA 90024, to support education, training, and clinical care in child psychiatry. For additional information, please contact Reema Prasad, Child Psychiatry, at ReemaParsad@mednet.ucla.edu.

Obituary reprinted courtesy of Polly Estabrook and James McCracken, M.D.

Dr. Mark DeAntonio served as a former president of the Southern California Society of Child and Adolescent Psychiatry.

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Keeping Them Close: Alternative Crisis Response for Youth

Emily T. Wood, MD, PhD



Over the last decade, the mental health needs of children have risen without a corresponding increase in community and school mental health services, leading to emergency departments and law enforcement being the first line of response to families experiencing behavioral health

crises.¹ From March to October 2020 the rate of ED visits for mental health emergencies increased by 24% for children ages 5-11 years old and 31% for youth 12-17 years old -- and the numbers have continued to rise.² The mental health resource gap between BIPOC children and their White peers has continued to widen as evidenced by the disproportionate impact of COVID-19 on families of color and the growing suicidal death rate among Black youth. For BIPOC youth as compared to White youth, law enforcement responses are more likely to lead to juvenile carceral involvement and trauma for families rather than connection with appropriate mental health services. Youth are at especially high risk for experiencing race-based traumatic stress from discriminatory racial encounters in the setting of personal and family mental health crises.³

In 2020 the FCC designated 988 as the 3-digit number to take the place of the National Suicide Prevention Lifeline (NSPL) and "to aid rapid access to mental health support services."⁴ Starting on July 16, 2022, phone companies across the country will be routing calls dialed 9-8-8 to the caller's local mental health resources, as coordinated by state and local governments. This initiative presents a unique opportunity for the behavioral health system to implement an equitable, inclusive, timely, trauma-informed behavioral and mental crisis response for all communities that relies as little as possible on law enforcement. A key component of this response is to connect youth and their families to mental health resources in their communities. This requires better integration of mental health and crisis care into primary pediatric care, school settings, and families' homes. Furthermore, it requires

providing culturally competent services that are inclusive of Black, Indigenous and People of Color (BIPOC), immigrants, LGBTQ and other minoritized youth and their families

The story of 16 yr. old Kei'Jay illustrates ways in which our current mental health system is broken and presents opportunities for improvements in care through the 988-system outreach into school settings. Kei'Jay is a bright Black male teenager with a history of chronic intermittent homelessness, untreated ADHD, and trauma exposure. Despite going through periods when he and his mother were living out of their car, Kei'Jay attended elementary school consistently and made good grades. In middle school, he struggled with managing multiple classes and started to smoke marijuana with friends. His mother became alarmed and reached out for help at his school. Instead of receiving mental health or social support services, Kei'Jay's current living situation was flagged as problematic, the Department of Child and Family Services (DCFS) was notified, and he was moved to a group home placement. With the separation from his mother and placement in a new school, he had difficulty making friends and became increasingly dysregulated. Within a couple weeks he got into a fight at school and was suspended and sent back to his group home. He soon eloped so that he could be with his mother. His mother was worried that she would be reprimanded if Kei'Jay was found with her before the DCFS case was resolved, so she turned him back over to DCFS. Kei'Jay felt rejected by this mother and depressed. He got into another fight at school and was again suspended. This time when he eloped from the group home he did not go to his mother. He spent the next 6 months staying with friends at night and selling candy by day to support himself. When I met him at the Juvenile Hall he had been detained for charges of burglary and carrying a firearm. During his time on the street, he had witnessed a friend being shot and then die and had been shot at himself. He reported depressed, negative mood, nightmares, hypervigilance, and intrusive

thoughts about the traumatic experiences. Initially, he had difficulty focusing on schoolwork but was soon willing to take medications to treat his ADHD and depression. He started to enjoy school again.

For many BIPOC youth, mental health crises that occur in school serve not as the access point to mental health services, but as a slippery slope to exclusionary discipline via suspensions and expulsions. Exclusionary discipline is the backbone of the school-to-prison pipeline as one suspension or expulsion can triple the likelihood that a youth will become involved with the juvenile carceral system in the subsequent year.⁵ Such inequitable discretionary discipline is disproportionately applied to the most vulnerable youth, including minoritized students, students with disabilities, and students identified as LGBTQ. In California, 28% of Black K-12 students with disabilities have been suspended at least once.⁶ As 988 is implemented and California makes efforts to build and strengthen the behavioral and mental health crisis response system across the state in the coming years, child and adolescent psychiatrists must advocate for resources that strengthen families and schools. These will include school-based crisis services, rapidly deployable mobile response teams that function with the goal of keeping families together, and crisis stabilization units that support families. Most importantly, these resources and services must be equitably provided to grant the most support to our most vulnerable youth.

Editor's Note: AB 988 (Bauer-Kahan), which would have been the vehicle in 2021 to implement the federal initiative in CA, failed to pass through the state legislature for various reasons including lack of an acceptable funding source, lack of a detailed provision to involve local government and resources. Insofar as children and youth are concerned, there was no provision to address specialized accommodations to address the needs of this population. The telecommunications industry was in strong opposition. Nonetheless, the governor approved \$20 million to help launch this new service in September and additional funding is available in the FY 22-23 budget. While the national line will be functional in July 2022, it will not be functional in CA for the foreseeable future.

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Charles R. Drew University Is Poised to Train the Next Generation of Physician Healers in Child and Adolescent Psychiatry

By Amy Woods, MD, and Nithya Ravindran, DO



Charles R. Drew University (CDU) was founded in South Los Angeles in 1966 to address the health disparities of the community highlighted after the Watts Rebellion of 1965. The uprising was primed by decades of structural racism resulting in disparities of economics, housing, and health in the Black community of South LA. As the only Historically Black Graduate Institution (HBGI) on the West Coast, as well as a charter member of the Hispanic Serving Health Professions Schools, Charles R. Drew University has been transforming medicine by training leaders that are committed to dismantling the systems of oppression that drive health disparities. To accomplish this, the training programs at CDU are guided by principles of specialized research, social justice, global service, health policy and community engagement.

The same structural inequalities that instigated the Watts Rebellion and led to the founding of CDU have continued to persist. The murder of George Floyd in 2020 propelled the social movement for racial justice to the mainstage again. 'The global pandemic and ongoing racial injustices have demonstrated the interconnectedness of our lives with each other, but also the aspects of an individual's environment including families, communities, physical environment, and societal structures. Marginalized communities have faced further widening of chasms of inequality, and existing structures of oppression have been exacerbated. The effects are evident in the state and health of our chil-

dren.¹ As a country, we have failed to protect our children of color from the harms of racism, which permeate every aspect of their human experience. It's only recently that major national physician groups, such as The American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA), have acknowledged a national state of emergency in child and adolescent mental health. However, for far too long we have been complacent in accepting children of color bearing the burdens of social injustices and structural racism, to the detriment of their mental health.

Denese Shervington, MD, MPH, Department Chair of Psychiatry and Assistant Dean of Graduate Medical Education at CDU, whose career has been at the intersection of public health and psychiatry, has actively addressed health disparities, social determinants of health and strength in underserved communities, because she has recognized children of color have always borne the burden of social injustices. In New Orleans, she has had tremendous impact on the narrative around trauma in Black youth and creating post-disaster healing spaces through her work including the Institute for Women and Ethnic Studies (IWES), which she founded in 1993. She came to CDU to continue this work in South LA. With her vision of promoting the well-being of a community by centering the healing needs of children, she has guided the growth and efforts of CDU's psychiatry department to include a CAP fellowship. In 2020, the CA Department of Health Care Access and Information (HCAI), formerly CA Office of Statewide Health Planning and Development (OSHPD), awarded CDU under the leadership of Dr. Shervington a five-year grant to address workforce shortages of child and adolescent psychiatrists in SPA6. The funding source is the Mental Health Services Act, which was signed into law 2004, supports

training; HCAI administers the training funds.

Materializing a vision requires leaders who understand the vital importance of the people who are tasked with implementation. Dr. Shervington selected this team by utilizing her experience of creating meaningful systems change. In actualizing Dr. Shervington's vision, the team built a program that is child-centered and focused on healing. Aligning with the program's fundamental values, clinical partners who have a deep commitment to serving under-resourced communities were chosen. These partners serve as the ground on which CDU fellows will develop into child and adolescent psychiatrists who are compassionate, social justice advocates, and excellent clinicians.

In July 2022, CDU will welcome its inaugural class of two fellows to the Child and Adolescent Psychiatry Fellowship Program. CDU fellows will be required to engage with the community within the clinical setting, and beyond. As medical professionals, we have been naïve to think that staying within the boundaries of the clinic walls will lead to healing the wounds of injustice that have been neglected for far too long. Child psychiatrists understand the interconnectedness of children, families, community, and society as it impacts the child. For the child to fully heal, we must be active participants in healing all those elements and be willing to expand our reach beyond the confines of the clinic.

CDU is poised to train the next generation of physician healers in child and adolescent psychiatry. To stay true to the mission described, the child and adolescent psychiatry fellowship program at CDU is guided by the question, "are we advocating for the child or the system?"² At CDU, the answer will definitively be, "the child." Doing so will create an environment for all children to heal. Within this philosophical framework, fellows will be nurtured to become champions of children and families both locally and globally and their learning of medical knowledge will be enhanced with human connections to the history and vitality of this area of Los Angeles.

As training directors, we invite others to collaborate and commune with us to center healing in our work

as physicians and educators. We all have a responsibility to champion children's rights because we can no longer be blinded to the injustices that inform the experiences of those around us. We hope that in doing so, we can collectively imagine a better world for all of us.

**Amy Woods, M.D., Program Director, and **Nithya Ravindran, D.O., Associate Program Director, of the Child and Adolescent Psychiatry Fellowship, Department of Psychiatry, College of Medicine at Charles Drew University.*

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To Whom Do We Listen? Discrimination and Epistemic Injustice in Child and Adolescent Psychiatry

By Helen Wyman, M.D.



Collateral, collateral, collateral! If there is one thing that every psychiatry trainee learns during training, it is the importance of collateral information. Certainly, in some – perhaps most cases, collateral is a good thing, as it may mean the patient has a family member or friend who is willing and able to support them through whatever pain or illness it is that the patient is experiencing.

In child and adolescent psychiatry, we rely heavily on collateral from caregivers who are often presumed to be reliable sources of information. On the other hand, we are often more skeptical regarding the child or teen’s narrative, suspicious that they are the ones not telling the truth. A fear of being “tricked” seems to abound. But why are we more prepared to doubt the child’s story more than the parent’s version? Even when parents report quite absurd and improbable events, or give vague or inconsistent histories, there seems to be little question of their version of events. Of course, it is not always one or the other. There is usually some part that is true. Or perhaps all that the parent said is technically true, but what is missing from the story is everything else that explains the “why” of the child’s behavior.” I have noticed that in many child-service settings, the “right” answer, or “what really happened” remains the narrative of whoever has more power – the teacher, the parent, the babysitter, or even the bully.

So why is this the case? Why is the child the one that everyone, including clinicians, therapists, teachers, and even parents seem to believe the least? Why do we as psychiatrists sometimes default to doubting the child more than the adults?

Because They Are Psychiatric Patients

Part of the reason that we doubt accounts of children and youth we see is that they are the identified patient. As I wondered and sought explanations for this seeming blind trust of caregiver accounts, I realized that if we saw these same parents as adult patients, we certainly would at least start with some skepticism toward their accounts, too. The only difference in the child psychiatry setting is that the patient is now the child, and it is as if this not only makes the child less reliable but means that everyone around them is more reliable.

Medical practitioners often seem to be less likely to believe what psychiatric patients tell them (Crichton, Carel, and Kidd, 2017). In addition, the very nature of psychiatric training encourages some appropriate skepticism toward our patients, which is often why we so value collateral information. For example, in a cardiology visit, collateral information would be rarely gathered, apart from perhaps prior medical records, often to reference labs or imaging. It is only in a psychiatric visit where, by default, the patient is not believed, and diagnoses may be made largely on others’ reports. Some scholars refer to this as epistemic injustice (Drożdżowicz, 2021) – a patient is presumed to be being incapable of “knowing” their own experience. Their experience, in essence, becomes irrelevant.

Because They Are Already Oppressed

I would be remiss not to mention the historical and ongoing uses of diagnoses as tools for oppression. Consider “hysteria” in women. Freud, in the earlier part of his career, took a unique approach to psychiatry. He took the time and effort to listen to these women who had been deemed “hysterical” by society. It is within these narratives that he found stories of child sexual abuse, and his initial theory was that these incidents of child abuse had occurred. Then,

however, he faced resistance in the medical community, later leading him to revise his theory as one that would explain these women's "stories" as "fantasies."

If they acknowledged that perhaps these women with "hysteria" at the time were exhibiting reactions to and sequelae of child sexual abuse, then they can't be labeled as "mentally ill", and oppression can't remain justified. This would come down to challenging some men, including some men in power, and that – would certainly cause a disturbance. Later, when it was increasingly accepted that child sexual abuse did in fact occur, the next best thing to permit ongoing oppression was to invalidate and minimize the subjective experience of women that had been sexually abused. In the 1975 version of the *Comprehensive Textbook of Psychiatry* by Freedman, Kaplan, and Sadock, authors describe child sexual abuse as a "offer[ing] an opportunity to test in reality an infantile fantasy[...] Such incestuous activity diminishes the subject's chance of psychosis[...] The vast majority of them were non the worst for the experience" (*Freedman, Kaplan, and Saddock, 1975*).

It is those that are in power that drive what becomes labeled as pathological and problematic. Indeed, there is no DSM-5 diagnosis for over-compliance, perhaps because it seldom if ever causes problems for those with greater power. And yet over-compliance is a common result of childhood emotional abuse, often indicating an absence or annihilation of the self, substituted by a "false self" that meets their caregiver's and subsequently many others' needs (Rees, 2007).

Double Abuse: Our Part in Perpetuating Injustice

Some scholars have described a phenomenon called "double abuse," in which those in power worsen interpersonal abuse by treating it as a typical conflict, attempting to "mediate" the situation, the dominant voice being that of the abuser, who pre-emptively attempts to take superficial responsibility, prematurely professing a change of heart (McDugal and Behel, 2021). When someone says that all they want is to reconcile or have a better relationship, we as mental health professionals typically jump at the opportunity

to help. Indeed, much of the time, double abuse is enacted by those in power without intention. Be it clergy, counselors, teachers, principals, therapists, or physicians, the focus on fixing the problem, resolving the conflict, or "promoting healing" is the goal being pursued. The problem is that in these situations however, the person in the driver's seat is often the person who already has power in the relationship.

In some cases, engagement with the family as a unit when working with children or youth is helpful and necessary. But in all cases, we need to carefully examine the power dynamic embedded in the relationship before us, which can sometimes be hidden under the silence and passive acquiescence of the victim. Without such close evaluation and awareness of power in the relationship, the acting professional sometimes even pressures victims into premature reconciliation, often worsening the abuse (McDugal and Behel, 2021). In the case of children and caregivers, the caregiver will almost invariably have more power because of the nature of attachment and the basic fact that the caregiver has almost all legal rights relating to the child.

Another common approach in mental health treatment is that of encouraging patients to empathize with others' difficulties (Sardina and Ackerman, 2022). Yet in cases of emotionally abused children and youth, one of the principal issues is the very fact that they are overwhelmed and over-extended trying to intuit and accommodate others' (often their caregiver's) emotions (i.e., Winnicott's "false self"). They are so occupied with feeling the feelings of others that they often do not have their own sense of self. And yet, often, we tell these very children to continue to sacrifice their own sanity, to sacrifice their own needs for the sake of adults' needs. Is this fair? Is it not the case that it is our duty as adults to understand children, not the other way around?

Advocacy: Amplifying the Voices of Children and Youth

In her book, *Spare the Kids: Why Whipping Children Won't Save Black America*, Stacey Patton, a child abuse

survivor, interviewed black parents who previously used corporal punishment about what made them stop. Among these accounts, one mother who stopped using corporal punishment cites a conversation that was life-changing in which a friend said, “We don’t respect childhood in this country.” (Patton p.214). The idea of respecting children may seem strange to some of us, because so many children and youth are brought to our attention because they are being disrespectful to their parents. It is not uncommon that parents ask, “How do I get [the child] to treat me with respect?” It becomes the parents’ experiences of feeling disrespected and the child’s “defiant” behaviors that become the focus of the conversation. What about if the child feels disrespected? Don’t they have a right to be treated with the respect that every person deserves? Or do they not count as people?

Medicine, child welfare, and schools have responded to calls for increased participation of service users. Yet efforts in this area within child-serving fields has largely focused on the experiences and perspectives of parents and caregivers. Consider the DSM-5. Parents were given the opportunity to contribute to the updates and changes made in the DSM-5 specifically regarding childhood disorders. What about children? Do they have a say in what it feels like to “experience” these disorders, if in fact they are disorders? Do they experience it as a disorder at all?

Perhaps the greatest overarching form of discrimination that leaves children in harm’s way is the systemic bias of adultism which values the perspectives, needs, desires, and experiences of adults above those of children, at times failing even to see children as whole persons (Bettencourt, 2020; Dziri, 2022; Corney, Cooper, Shier, et al, 2021; Singh, 2013).

We must advocate for children and youth. To be clear, I am not talking about advocacy for higher reimbursement rates or other processes that would improve physician workflow, system barriers that we personally experience. These of course are important as well and are already pursued by child psychiatrists. But there is a fundamental difference between advocating for what we believe to be best for children and advocating on behalf of children. Many of the greatest mistakes in his-

tory have been made in the name of child welfare, pursuing solutions that adults unilaterally decided they knew what would be “best” for children. Consider Operation Pied Piper in the late 1930s. Children were *voluntarily* sent away to secure their physical safety, while separating from their mothers. And while at least arguably well-intentioned, it would have drastic consequences as Winnicott later detailed.

We Are Not Powerless.

Of course, there are entities and people that have greater power than physicians. As a result, we as physicians, social workers, therapists may at times feel helpless and powerless against an unchanging system. Physician-writers such as Groopman and Gawande have written about the fact that they are not able to change many of the aspects of medical practice they had hoped to change when they first entered medical school. Instead, they seem to shift the responsibility to the medical system or the system at large. But individuals do make up the system, and our acquiescence and passivity does play a part in preventing system change. And if we all sit together and say that it is out of our hands, and that it is a “system problem,” what about those with even less power than we have?

Power is relative, and children and youth, especially those subject to other forms of racial, sexual, and gender-based discrimination, are the ones with the least power in modern America. Of course, some parents become advocates for their children and encourage their own children to advocate for themselves. But the vast majority of children suffer from the effects of adultism and do not have a voice. Who will advocate for them? Is it the job of the child psychiatrist, therapist, the case worker, the child protection worker, the primary care doctor, someone else, or no one? Is it not the job of all of us working together? And if systems are immovable, with seemingly insurmountable obstacles, wouldn’t finding a common and united priority such as that of empowering children, have the greatest chance of success?

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SCSCAP Educational Event - Michael Strober, PhD on Eating Disorders

By Patrick Kelly, M.D.



On Sunday, March 13, 2022, members were treated to a presentation on eating disorders in Children and Adolescents by one of the world's premiere experts on the topic, **Michael Strober, PhD**. Dr Strober joined the Department of Psychiatry at UCLA in

1975. Since 1983 he has served as Editor-in-Chief of the International Journal of Eating Disorders. Dr. Strober has authored nearly 250 scientific articles and book chapters. He currently serves as the Resnick Endowed Professor of Eating Disorders and Psychiatry at UCLA and directs the eating disorders program.

Dr Strober started the discussion by informing participants that his talk would primarily be limited to the evaluation and diagnosis of anorexia nervosa, and even then, believed that the breadth of the topic likely exceeded the time allotted given the complexities of the patients he sees with this condition. He began with the story of a particular patient he had treated in the past, with the identity obscured of course for privacy. He used this patient to illustrate the core features of anorexia, which he described as an illness about control. The anorexic patient seeks to, indeed needs to, control everything in his or her life. The idea of losing control of their environment or their weight is unthinkable. This leads to supremely complex treatment, as the provider needs to carefully balance kindness and perceived autonomy with the requisite life-saving measures required to maintain safety and efficacy.

Dr. Strober reviewed the approach of the UCLA department in managing such complex cases, both on the inpatient unit and outside of the facility. He discussed controversies in the field regarding anorexia nervosa and how, in the past, approaches to the diagnosis and treatment of this condition have at times taken on a life of their own. He continued to emphasize the complex and diverse nature of these patients, pointing out that there is no one single best approach. For example,

although an understanding of the underlying genetic and biological predisposing factors to anorexia, and studies of patients undergoing starvation, have encouraged treatment of this illness along the same lines as other biologically based mental illnesses (BBMI), this approach often fails to adequately cover the wide variety of individuals suffering from this condition. Similarly, though on the opposite end of the spectrum, family-based therapy (FBT) has undergone swings in popularity and has been at one time or another seen as the treatment of choice for youth with this diagnosis, only to in some situations increase maladaptive coping behaviors among patients.

Dr. Strober wrapped up his discussion with an anecdote experienced during a walk-through Westwood with his daughter. He mentioned that he and his child were walking behind a rather thin individual, leading his daughter to ask if she would ever be at risk for developing a similar condition. He recalled telling his daughter that people who suffer from these types of problems are extremely focused on control, that they are aversive to new experiences, and that they want each subsequent day to be just like the day that came before, so, no, she was not at risk. These sorts of stories, though delivered with humor, also show the deep suffering of individuals with eating disorders, the fierce and joyless cage of rigidity in which they place themselves as a defense against the uncontrollable reality of existence. Giving patients safety and space to break free from this cage, an act apparently so easy to those without an eating disorder, can seem insurmountable to a patient and their family. In this way, Dr. Strober encourages empathy for the patients fortunate enough to be under his care, and again demonstrates his skill in behavioral modification through simultaneously attending to and recognizing the emotional needs and fragility of those with eating disorders, while also enforcing continual forward momentum towards change and freedom from these conditions.

The following are just a few of the comments shared by colleagues and former trainees of **Mark DeAntonio**:

Dear UCLA family,

It is with a heavy heart that I write to you all today. Two nights ago, our beloved Mark DeAntonio passed away comfortably in his sleep, surrounded by family. I am so sorry.

He was an incredible teacher, clinician, and human being. I think many of us looked up to him, as he represented the very best of what a child psychiatrist could be.

In one of our last conversations a few weeks ago, he took some time to reflect about life and what he values most. He stressed the importance of doing what is right, which can be hard, and to never waiver when following your moral compass. He spoke about the love he had for his family - especially his new granddaughter - and how working with trainees "was the greatest gift." I didn't realize until now that he was saying goodbye.

The world has lost a legend. We will honor his memory everyday in the good work we do. Thank you for being such a meaningful part of his community.

Thinking of you all and with love,
Misty and Sheryl

"This is so incredibly sad. He is a colossal pillar in my mind of what a doctor, a psychiatrist, a father, a husband, a friend should look like. He occupies a big part of my good feelings about my life here in LA. I will truly miss Mark. And it's a sadness with a panic. Who can ever fill his shoes? No one. Thank you Misty and Sheryl for keeping me in the loop. Love and peace to you all as we pick up the pieces and head into 2022."

Deborah Lynn





“Thank you for telling us. So many of us felt he was the father figure of our training. I benefited greatly from his teaching and perspective, and had some truly memorable experiences with him. You can all imagine the look on his face as we rounded early on a Saturday morning when I confessed I had not called Dr. Shah the night before about a new admission (I had forgotten this small procedural step). Thank you for sharing his thoughts on the gift of working with young clinicians and doing what’s right. He was a man of principle and integrity and such an insightful clinician. A great loss for us, UCLA, and the children we care for. “

With Sadness and Affection,
Zeb Little

“Thanks Misty and Sheryl for sending this email. I was devastated to hear of his passing, but this email brought some bittersweet joy as I could imagine his face and hear his voice say the things you mentioned above. Thinking of you all and sending lots of love to the UCLA and DeAntonio family as well.”

Michelle Wu

“Misty, thank you for sharing your conversation with Dr. Deantonio. I called him a few months ago to get his advice and opinions on a hard case. He spent more time asking about me, how I was adjusting, giving me advice about relying on my clinical intuition and about leadership on the unit. He was so kind and told me to "call me whenever". I only regret that I didn't take him up on his offer to have another chat.”

Lavanya Wusirika

“My heart hurts for the loss. And I am so sad for all those who will not have the honor of being mentored by him.

Thank you for sending this.”

Brooke Spanos

“I was in Italy until yesterday and unable to prepare a video, but I emailed him a big hug of an email, which I hope he got. Mark was very important to me. Your email is a reminder that - for all his quirks, that often brusque, rough way of his, his stinginess with smiles and praise - he was important to so many of us. I think part of the gift of the UCLA fellowship was figuring out Mark while figuring out child psychiatry!”

Robert Haskell

Child and Adolescent Advocacy

By William Arroyo, M.D.



Advocating for our profession and our patients continues to be a critical activity for organized child and adolescent psychiatry. On the state level, the California Academy of Child and Adolescent Psychiatry is hosting its virtual advocacy day on May 16.

CALACAP has been working on many bills during this legislative session. Key legislative, policy, and programmatic issues include the effort underway to dismantle the Medical Injury Compensation Reform Act (MICRA) which is headed to the November ballot which, if passed, would threaten the health care delivery system in California due to the drastic restructuring of medical malpractice insurance. The Act has been a model for the rest of the country in keeping malpractice award amounts at minimal levels. The ballot initiative, however, seems to be favored in current polling. An agreement among the key constituents in this debate including the California Medical Association and the governor's office took place recently; an agreement to restructure MICRA was reached by way of a bill, AB 35 (Reyes) which CALACAP supports, that allows for a gradual increase in malpractice award amounts during the next several years. While it is not a bill acceptable to all physicians, this may be the best possible option at this time. Furthermore, the estimates of a campaign cost to defeat the ballot initiative have been daunting. If the bill arrives at the governor's desk before the end of June, the ballot initiative will be moot. Another major issue is the ongoing rollout of the new Medi-Cal plan for CA, CALAIM, which has had major hiccups, including a faulty rollout of the new pharmacy component, CalRx. In addition, the rollout of the Child and Youth Behavioral Health Initiative (CYBHI) which was funded to the level of nearly \$4.5 billion dollars is ongoing. A recent component of CYBHI emerged which was establishing a think tank to advise the state Department of Healthcare Services on the selection of evidence-based practices which will be implemented statewide; two CAP's were selected to be members. Another interesting bill is AB 2317 (Ramos) which

would establish children's crisis inpatient services which, surprisingly, would be provided in non-hospital facilities; CALACAP is negotiating with the sponsor of the bill to make it better one by including a role for organized child and adolescent psychiatry. AB 2408 (Cunningham) is an attempt to reform social media platform companies which target children to become "addicted" to these platforms and would allow parents and others to sue these companies; while it may seem like an honorable intention, this may not be implementable according to its opponents. These are a just a handful of activities that CALACAP has been addressing in Sacramento. Marcy Borlik, M.D., and I are your CALACAP delegates.

On the national front, the American Association of Child and Adolescent Psychiatry conducted its virtual legislative advocacy day on May 11 with nearly two hundred child and adolescent psychiatrists, including CAP fellows and medical students, participating representing more than thirty states. There were three advocacy issues discussed. The first related to Access to Child and Adolescent Psychiatrists. Attendees who met with the offices of their US Senators and House Representatives stressed the ongoing dire shortage of CAP's, the specific state shortages, and finally a request to support HR 7236 "Strengthen Kids' Mental Health Act" which was introduced by Rep's Anna Eshoo (D-CA), Lisa Rochester (D-DE), and Brian Fitzpatrick (R-PA); the senate version had not been introduced. This bill would support parity in Medi-Cal for children's mental health services, incentivize the integration of behavioral health across child serving systems, and expand recruitment of mental health professionals. We also addressed the CAP Workforce challenges. In addition to the data related to CAP workforce shortages, the staff of our elected officials learned that loan debt accrued by many trainees was a disincentive to pursue additional training in child and adolescent psychiatry to many residents in general psychiatry. A request was made to get office co-sponsorship of HR 3150 "Advance the Mental Health Professional Workforce Shortage Loan Repayment

Act” as a partial solution. This bill would establish a loan repayment program for CAP’s and other mental health professionals who work in designated workforce-shortage areas and authorize up to \$250,000 in loan repayment. And the third issue was Improving Equity in Access to CAP. A request for the co-sponsorship of house bill HR 1475 and senate bill S. 1795 was made to our house representatives and senators. The bills would expand programs to address racial and ethnic disparities in mental health through grants to behavioral health organizations in largely minority communities; support the development of health professional core competencies to address racial and ethnic minority mental health disparities; and reauthorize and support SAMHSA minority fellowship program. During the wrap-up discussion, it was apparent that the AACAP has a lot of support for these bills and that many of the participants, especially young CAP’s, strongly appreciated the opportunity. A shoutout to Robert Holloway, M.D., who was the very capable California captain.

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