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THE SAN DIEGO PSYCHOLOGIST

The Official Newsletter of the San Diego Psychological Association

In this issue

President's Corner

by Cynthia A. Cotter, Ph.D.

Welcome to the first 2018 issue of The San Diego Psychologist, the official newsletter for the San Diego Psychological Association! SDPA continues to be grateful for the efforts of our talented editor, Gauri Savla, Ph.D. who has done such a wonderful job for the past two years, starting with the design of new online Newsletter that is easy and pleasant to read. The task of the editor is quite challenging as she must develop a theme for each issue, find writers knowledgeable and skilled in the topic area of focus, orchestrate timely submissions of articles, edit each article, and finally format it with graphics for publication. We so appreciate Dr. Savla's contribution to our Association and we look forward to another great Newsletter year.

The plan for the year is to publish four issues of the Newsletter, each on a single theme. The current issue spotlights our SDPA collaborative conference **Critical Issues in Child and Adolescent Mental Health (CICAMH)** focusing this year on adolescent brain and identity development. We have a superb lineup of speakers this year; Don't miss it! The second issue will present articles on the theme of mental health disaster response anticipating our Spring Workshop on this topic. Speakers for our Fall Conference will provide articles for the third issue on what to do when we encounter substance use in clinical practice. Finally, a December issue is planned on working with older adults. Please consider writing for one or more of these issues; early submissions to future issues ensure timely publication, so it is never too early to submit an article, propose a topic you may want to write about, or nominate potential contributors.

I am pleased to inform you that our Association is flying high! The organizational restructure begun in 2016 is now complete. We have much improved finances, a

reorganized, more efficient Board, notable increases in membership and attendance at events, a lovely and efficient new office manager (Tami Magaro), and a new website. We now average over 600 members and our 35 committees/taskforces carry out our missions to support the profession of psychology and to benefit mental health in San Diego. The energy and enthusiasm of members is just remarkable!

This year, we will focus on increasing benefits for members. With our improved finances, we will provide two free large networking events. The first, our now annual Brew Ha Ha!, will be held on April 8th . The second, an elaborate celebratory Winter Gala, will be held in early December. By popular demand, we are bringing back the Spring Workshop that will be held May 19th. The topic, **Preparing for the Unthinkable!**, is unfortunately timely; how we as mental health providers can contribute when one disaster strikes and more seem to follow, seemingly without relief. The topic of our Fall Conference is also timely, **Encountering Substance Use in Clinical Practice**. National speakers will discuss emerging issues related to substance use, particularly opiate deaths and legalization of marijuana. There will be talks reflecting divergent perspectives on conceptualization, assessment and treatment of addictions to substances.

Our very popular series **Dinner Case Conference in Del Mar** will continue, and we hope to expand to other areas of the county. SDPA continues to support many community activities including the NAMI Walk, the Harvey Milk Diversity Breakfast, and the Navy SEAL Foundation Impact Forum. In addition, we have four new committees, Addiction, Geropsychology, Military, and School Psychology.

If you are already an SDPA member, we so appreciate your participation. If you are not, there is no better time to become a member. We hope to see you soon!

Editorial

by Gauri Savla, Ph.D.

Dear SDPA Members and Guest Readers,

Welcome to the maiden issue of 2018! Since I took over as Editor of the San Diego Psychologist in 2016, I have had the unique privilege of having worked with three phenomenal SDPA Presidents—Dr. Ellen Colangelo, Dr. Annette Conway, and recently, our current President, Dr. Cynthia Cotter. Each of these women has influenced the evolution of the Newsletter with her unique vision and perspective; Dr. Cotter's forethought and attention to detail led us to determine the themes of all four issues for this year, a more streamlined and navigable website. Among other things, you may have noticed that it is easier to access past issues of the Newsletter by the year in which they were published and direct links to the SDPA website and upcoming events.

The Winter 2018 issue of the Newsletter is a companion issue to the upcoming **Third Annual Critical Issues in Child and Adolescent Mental Health (CICAMH) Conference**, and features articles from some of the experts who will be presenting their work there. Dr. Mulvihill's interview with Dr. Rowe, the Chairperson of the Conference gives a broad overview of the mission of this collaborative, and the agenda for this year's meeting. Dr. Boesky, a Distinguished Speaker at the 2018 CICAMH writes about the often heartbreaking and important work she does in suicide prevention and research. Mr. Rich's article on the Boys to Men initiative in San Diego County highlights this remarkable program that mentors fatherless boys. The interview with Dr. Giedd is a fascinating look into the teenage brain. Dr. Parks has written a passionate article about the stigma parents of children with eating disorders face, and presents some theories about why it continues to persist. The issue ends with two poems by Maya Salameh, a 2016 National Student Poet, and our very own Dr. Mulvihill. I want to extend my gratitude to Dr. Mulvihill for reaching out to the speakers and following up with them, a task that added hours to her already busy life.

As a clinician (and erstwhile researcher) who primarily works with older adults, I have great admiration and respect for mental health professionals who work with children and adolescents. Their work is challenging and sensitive, but their dedication to this cause is unparalleled. As Dr. Rowe says in his interview, just as with other special populations, caring, competent professionals specializing in children's issues are urgently needed to meet a rapidly growing need. Conferences such as the CICAMH not only bring allied professionals together, but hopefully, inspire new professionals just entering the field to consider working with this population.

Dr. Cotter, in her President's Message, has highlighted the themes for the four issues of the Newsletter this year. We hope that you will feel inspired to write for one (or more) of these issues to share your work, expertise, or opinions with your fellow professionals.

I look forward to hearing from you. As always, questions and comments on the specific articles or the Newsletter in general are welcome.

You may leave a comment on the online newsletter at www.thesandiegopsychologist.com or email us at TheSanDiegoPsychologist@gmail.com.

A Team Approach to Providing Care for Children and Adolescents with Complex Behavioral Health Challenges

Interview with Jeffrey Rowe, M.D. *by* Mary Mulvihill, Ph.D.

Dr. Rowe is the Supervising Psychiatrist at the Behavioral Health Services division of the County of San Diego Health and Human Services Agency. He is also the Chairman of the 2018 Critical Issues in Child and Adolescent Mental Health Conference, entitled, "Hidden in Plain Sight: Adolescent Brain & Identity Development."

Dr. Rowe, what is the purpose of the Critical Issues in Childhood and Adolescent Mental Health Collaborative that's being developed here in San Diego?

The San Diego CICAMH Collaborative is a joint project between the County of San Diego Health and Human Services Agency, San Diego Psychiatric Society, San Diego Psychological Association, San Diego Academy of Child & Adolescent Psychiatry, the San Diego Chapter of the California Association of Marriage & Family Therapists, UCSD Community Psychiatry, SDSU School of Public Health, and the American Association of Pastoral Counselors, Pacific Region. We hope to add social workers in the future.

There are three main purposes of the CICAMH Collaborative:

1. To provide an opportunity for five of the major mental health professional organizations to work together on a substantive project of benefit to the community. We don't often have the opportunity to get to know each other personally and professionally, so working on something we all feel is important helps us understand the various professional perspectives and talents and how we can best work together.

2. To provide the latest information on the treatment of children's mental health issues to our members, trainees, and to the San Diego mental health community.

3. To provide mental health professionals the opportunity to develop cross-professional relationships. This enables us to do a better job taking care of child/youth clients,

especially in a crisis situation or when dealing with very complex problems. CICAMH also puts together the annual Summer Social in August for our collective memberships to foster these relationships.

Since you represent child/youth psychiatrists, what should other mental health professionals know about how you operate when doing psychopharmacology with children/youth?

There are four basic treatment principles in considering psychopharmacology for kids: (1) It is important to appreciate that no one likes to medicate kids. Medication done poorly can be a problem. (2) Some kids have problems that can be severe & disabling. (3) Children deserve the very best treatment of ALL kinds available to address the problems they are contending with. (4) Effectiveness and side effects must be carefully monitored in all treatment interventions.

Medications, even when necessary, are not a sufficient treatment in themselves. New learning experiences, such as therapy, school activities, skill building, and new relationships are also needed to create a complete treatment approach, capable of creating new brain pathways.

Tell me more about how new learning experiences complement the role of psychopharmacology for children/youth experiencing difficulties.

There are many misconceptions and fears about the use of medication in children/youth. Chemicals we use as medicine only "work" because there are receptors in the brain that they "work on." So, in this way medicine acts as a "dial turner"; it can make the receptors and neurons work more or work less, depending on their intended effect. Medicine can make a person more active or less active. It can diminish voices (hallucinations) or amplify them.

But medications cannot heal a person. They cannot create new brain connections, better integration of nervous activities, or a new understanding of one's self or relationships with others. New activities, relationships, and skills that emerge in their daily life are critically important. These can be achieved through therapy, but also school experiences, outside mentors, animal interactions, sports and arts participation, and so forth. Medication can help these therapeutic experiences and changes happen by fostering safety, decreasing suffering, and improving cognitive function and self-control.

Are there any new medications or treatments which child psychiatrists are able to use now that other mental health practitioners should know about?

It is important to realize that all the current medications we have, including the "latest and greatest" for depression, anxiety, attentional focus, psychosis, and mood stabilization are based on very old science. We haven't had any new breakthroughs, unfortunately.

However, there are some new developments in what some would consider "recreational" drugs, which are now being studied. An example of this is ketamine, which seems to be beneficial for mood. It has the advantage of acting very fast; an infusion of ketamine can take

effect in minutes to hours, but lasts only a day or two. There is a lot of research interest currently in this drug's potential effects and how best to use it.

Transcranial Magnetic Stimulation is increasingly being studied, primarily for mood, but also for autism and anxiety. In this treatment, a magnetic force is applied across the skull to stimulate different brain areas or integrate their functions, so the brain works differently. This is a very exciting area.

Transcranial Electric Stimulation, the use of an electrical stimulus across the skull, is also being studied, but not as well or extensively. So, there are a number of new approaches on the horizon, which may provide new and effective intervention options for children/youth struggling with significant mental health issues which impair their function.

How can a child/family therapist find a good pediatric psychopharmacologist to work with?

This is difficult at present, unfortunately. We have 750,000 children in SD County, 500,000 of whom are over six years old. We only have about 100 child psychiatrists, supplemented by a number of excellent developmental behavioral pediatricians and some general psychiatrists who also work with adolescents. San Diego has two nurse practitioner programs for mental health, so we are also aided by excellent nurse practitioners locally, who serve a vital role in handling many cases. But there are just not enough practitioners to meet the demand.

One way we might start to meet this challenge of access to psychopharmacology treatment is by developing methods of determining which case is a "complex case," requiring the highest level of expertise and a collaborative team effort, versus a more straightforward or "simple" case, in which treatment by a "front-line" practitioner will suffice. We don't often think about or talk about cases this way, but we may need to start to do so in order to utilize our limited resources more wisely.

How can a child/family therapist and pediatric psychopharmacologist collaborate well together on a challenging child/youth case?

With any pediatric case, there are three basic aims: (1) to ensure safety, (2) to reduce suffering, and (3) to improve function. Each professional has their own role and expertise, based on a respectful collaboration.

The central focus must be on developing a good case conceptualization, ideally collaboratively. The child/family therapist often has critically important history and contextual information, which can help me, as a psychiatrist, understand what is dysregulating the child, and what might help achieve regulation again.

When a child/youth patient is having sufficiently severe symptoms for which medications are being considered, there is a lot of fear involved for everyone. The case conceptualization provides clarity, which is reassuring, and a road map to which evidence-based treatments may

be helpful. This needs to be applied to both medications and to the other therapeutic interventions proposed. It might seem like we don't have good ways to do this now, but if you put together a solid formulation (or case conceptualization), you can begin picking out the targets of your treatments, work to get agreement with your patient/client and family, and then apply the treatment. Periodically, one could then pause treatment, reassess the target symptoms, see if the treatment is having the intended effect and, if not, change course. This process is useful for both medication treatment and psychotherapy.

What factors go into a developing a good case conceptualization for child/youth client?

It is helpful to get a good "lay of the land" first. To do that, a thorough interview should be conducted with the child, his or her caregivers, and other important people in his or her life. The idea is to get an initial sense of how many areas of difficulty we are dealing with, and whether the case is "complex" or "simple." If "complex," one should try to determine when the problems started, what the course has been, whether any family history can help with determining diagnosis, what treatments have been tried, what stresses have been experienced, what protective factors are present, and whether any serious recognizable conditions are present [e.g., Fetal Alcohol Spectrum Disorders (FASDs) are "complex"; they can have multiple clinical presentations, cause severe dysfunction but have a known course and prognosis].

By figuring out when the problems started, you can then assess if the child ever had the necessary functions at age five to "go out into the world." Basically, we are assessing three main areas in order to plan treatment: (1) self-regulation, e.g., eating, sleeping, attention, aggression, emotions; (2) mastery, e.g., self-esteem, confidence to take actions, perseverance at working toward a goal; 3) well-being, e.g., ability to feel good, sense that one is going to be ok, sense of belonging, purpose, spiritual awareness. All of these areas have to be functioning well by age five to allow a child to go off and succeed in our rather lengthy, demanding form of kindergarten. A therapist who knows the child and family will have a good idea of what is going on in all these areas.

With older children/youth, there are more factors to consider. Often the psychotherapist or assessor has critically important information for me about what kind of stress or trauma the child is experiencing, when it started, and what the course has been over time. Formal assessments by psychologists may be very helpful. If a child is not doing well in school, understanding any learning differences or capacities can obviously be important. Projective testing is also often helpful with children, since some kids do not talk very much nor engage in much creative play, so are hard to assess. Projective testing gives a window into their internal world, what they ruminate about, what they are anxious about, etc., which may help understand them better and guide treatment.

With complex cases, both the child's psychiatrist and therapist have important, complementary roles to play. Each has to trust and respect the other's input, and carry out

their role effectively. Going back to my initial remarks, if we professionals rarely work together and don't get to know each other's viewpoints and expertise, it is harder to collaborate optimally when confronted with a challenging pediatric case within the time constraints and demands of clinical practice.

Can you tell me what we can expect at the upcoming 3rd Annual CICAMH conference on March 23rd and 24th, 2018 at the Towne & Country Conference Center in Mission Valley?

This is our third year – we have had a tremendous response from local mental health professionals to this combination of cutting edge information and networking. It's been a fun conference to attend. We have grown from 200 to 400 attendees. This year, we have expanded to 2 days for the first time. The focus of each day is a bit different.

The first day will feature a 3-hour morning workshop on teen suicide with forensic and troubled teen expert, Dr. Lisa Boesky; she will focus on how to assess suicidal teens, how to respond effectively, common mistakes to avoid, and how organizations can prepare for suicidal teens in their programs.

The afternoon will be devoted to the current state of psychopharmacology with children/youth, starting with the basics, to bring everyone on board. This will be followed by a focus on complex cases, which means cases where there are multiple issues, sometimes contradictory, which require a high level of expertise to address. We have two amazing experts coming: Dr. Gabrielle Carlson, from SUNY Medical School, who is an expert on complex presentations of ADHD and mood disorders and Dr. Glenn Elliot from Stanford University Medical School, who is an expert on managing aggressive and self- injurious behavior in children/youth.

The second day, the focus will be on how the brain's development unfolds during adolescence, and how it undergirds and integrates with important developmental experiences during adolescence. Much of this is going on before our very eyes, yet we often don't appreciate its significance – this process is "hidden in plain sight."

We will start with Dr. Jay Giedd, from UCSD, a longtime NIMH researcher who will outline the latest findings on adolescent brain development and its implications for therapists. Dr. Luis Nagy, psycho-analyst and computer scientist, will talk about new technology as part of daily life, and how this impacts identity formation, boundaries, and the conduct of therapy with teens. He will focus on how social media creates a developmental trajectory in a new dimension of identity pertaining to the virtual world, where many kids spend a lot of their time.

After lunch, we move onto some of the important modalities needed to generate those critical new learning experiences. Dr. Bonnie Goldstein will talk about the importance of creative movement and free play, integrating these sensorimotor and expressive aspects with their impact on brain development. Kids need to be physically active to develop in a healthy way. The Boys to Men program, which provides community based mentoring to fatherless boys,

will discuss the important role of adult relationships in development – how to be a good mentor and what benefits that provides.

Finally, Vinny Ferraro, renowned youth activist and mindfulness teacher from the Bay area, will address the emotional and spiritual benefits of deeply connecting with troubled kids. His experience "being there - fully present" with incarcerated teens and bringing mindful awareness into schools and institutions is inspiring. We will end with an illustration of how music can foster a sense of belonging, inspiration, and expression.

We are incredibly lucky, in part through the generous support of a grant from The County of San Diego Behavioral Health Services, to be able to bring these internationally renowned speakers here to San Diego, so we can create an affordable conference with two networking lunches and a Friday evening reception to foster community.

We will also have a number of exhibitors from local programs which serve children/youth so it's a great way to survey many available community resources and meet their clinicians. It should be an enjoyable, informative day. Please consider joining us and adding your voice to our developing interdisciplinary professional community.

Youth Suicide: Are You Aware of These Key Issues?

by Lisa Boesky, Ph.D.

- *Robert, 11, struggles in school academically and behaviorally, is regularly teased and harassed by classmates, and was recently overheard saying, "I can't take this anymore."*

- *Carrie, 16, is a popular honor student and talented athlete. When her boyfriend broke up with her and began dating her close friend, she was devastated and humiliated. Carrie's grades began to suffer, she dropped out of sports, and seriously contemplated killing herself.*

- *Lucas, 17, had repeatedly been involved in physical fights, regularly drank alcohol and smoked marijuana, and was close to failing out of school. After an arrest for drug possession, he found a gun in his family's home and took his own life.*

For the past two decades, I have travelled around the country providing training, consulting and serving as an expert witness on issues related to adolescent Suicide. I am devastated and heartbroken by how many of these cases may have been prevented. "How did we miss the signs?" is a question often asked. Psychologists can play a critical role in identifying youth at risk of Suicide, as well as educating parents/caretakers and professionals who regularly interact with young people (e.g., education, healthcare, juvenile justice, social service, clergy) on how to recognize these youth.

Some key facts about suicidal youth include:

- Suicide is the 2nd leading cause of death among young people ages 10 to 24.

- More than 1 out of 6 high school students have seriously considered Suicide in the past year.
- Lesbian, gay, and bisexual youth are almost five times as likely to have attempted Suicide compared to heterosexual youth.
- Girls think about Suicide and attempt Suicide more often than boys; however, boys *die* by Suicide much more often than girls.
- Most teens who attempt Suicide experience unbearable emotional or psychological pain and see no other way to end their suffering.

This article highlights just a few of the issues related to how we miss some Suicidal youth.

Depression in Teens

The majority of adolescents who die by Suicide suffer from one or more mental health disorders, most typically Major Depressive Disorder or Bipolar Disorder. Unfortunately, many of the adults who interact with teens (parents, teachers, coaches, clergy, physicians, etc.) do not recognize symptoms of Mood Disorders among adolescents; this is especially true for high achievers in academics or athletics or youth who repeatedly get into trouble at school or with the law. Sadly, suicidal youth who have a mental illness are often undiagnosed and untreated or misdiagnosed and mistreated.

The most recognized signs of Depression in youth include:

- Sadness
- Crying often
- Withdrawing from friends
- Withdrawing from activities
- Talk of wanting to die
- Suicidal behavior

The least recognized signs of Depression in youth include:

- Irritability
- Agitation
- Anger
- Fatigue
- Concentration problems in school
- Restlessness
- Changes in weight
- Insomnia/Over-sleeping
- Somatic symptoms (e.g., frequent stomachaches, headaches)
- Alcohol or drug use/increased use
- Change in friends

- Behavioral Issues in school

Psychologists can play a key role in educating others that many youth who appear "mad" or "bad" may actually be "sad." Helping adults realize that even if these youth are not sad, treating their "mad" moods and/or "bad" behavior can significantly reduce their risk of Suicide.

Youth Self-Report

Interviewing youth at risk for Suicide is essential. However, some adolescents may minimize, deny or exaggerate their suicidal thoughts or feelings. *In addition* to talking with youth about thoughts and feelings related to dying or killing themselves, psychologists must also take into account their observable behavior, history, current environment, and current level of support.

Some teens suffering from emotional or psychological pain may not want to talk to adults— including mental health professionals— about their innermost thoughts and feelings. Some professionals expect suicidal youth to report key words or phrases (Suicide, kill myself, want to die, etc.) during screening or assessment, but may never hear them. A variety of adults may hear statements related to a youth's suicidal thoughts and feelings that may not be obvious enough to cause alarm. Friends and peers may hear clues or even frank statements about suicidal thoughts and feelings, but may be reluctant to relay them to an adult in a position to help.

Typical statements that should alert a professional, other adult or peer to potential suicidal ideation include:

- I want to go to sleep and never wake up.
- I wish I could disappear forever.
- I wish I were dead.
- I won't be a problem for you much longer.
- You'd be better off without me.
- If a person did ____, would he or she die?
- It hurts so much, I just can't go on.
- Life's just not worth living.
- No one would miss me if I were gone.
- Maybe if I died they would finally see how much they hurt me.
- Maybe, I should just kill myself….just joking.

Themes related to youth feeling alone, that they do not belong, or that they are a burden to those around them should be particularly concerning.

Self-Injury

A number of teens secretly cut, scratch, or burn their skin in an attempt to feel better. Although known by various terms [e.g., self-injury, non-suicidal self-injury (NSSI), self-mutilation, "cutting]," this behavior reflects a youth's deliberate harming of his or her own body without the intent to die. Self-injury can consist of superficial scratches or cuts, or deep carvings and wounds on the forearm, ankle, stomach, leg or another body part.

Young people give a variety of reasons for engaging in self-injury, including, but not limited to:

- Trying to gain control or distract themselves when overwhelmed by strong emotions or unwanted thoughts.
- Releasing unbearable tension.
- Wanting to feel "something" or feel "alive" when feeling "numb" or "dead inside."
- Communicating with others or expressing themselves when having difficulty doing so verbally.
- Punishing themselves.
- Experiencing a temporary but intense feeling of euphoria that occurs in the immediate aftermath of hurting themselves.

Self-injury and Suicide are two different behaviors and should be assessed and treated as such. However, these two distinct behaviors can occur simultaneously. And most importantly, engaging in self-injury is a major risk factor for Suicide.

When psychologists assess youths' Suicide-risk, they should always inquire about self-injury. Similarly, when working with youth who self-injure, their suicidal thoughts, feelings and behaviors should always be assessed.

Latina Adolescents

Latina teens (particularly those born in the US to immigrant parents) report higher rates of Suicidal thoughts and attempts in comparison to their peers. There is not enough research to tell us why, but potential theories include:

- ➢ Some parents who have immigrated to the US may have limited knowledge of mental illness (including symptoms of Depression and warning signs of Suicide).
- ➢ Stigma around mental health can result in some Latino families wanting to deal with psychological issues within the family, rather than seek out mental health professionals.
- ➢ Parents who have immigrated to the US may not have the resources to access mental health treatment or there may be little to no mental health services in their local community.
- ➢ When these families do seek out mental health assessment and treatment services, assistance is often not culturally competent.

Some first-generation Latina teens describe typical teen challenges compounded by communication issues and conflict with their parents due to differing values and priorities. They report being conflicted between their parents' expectations that they make the family their priority, be at home when not at school, and help to care for family members versus their own desire for independence, including wanting to spend time with friends, date, or get a job.

Some young Latinas suffering from Depression or Anxiety describe not wanting to "burden" their parents with their "problems" because their parents have worked so hard and sacrificed so much for their children.

The Importance of Access

Suicide deaths among young people can be substantially reduced, even without mental health treatment, by making it more difficult to die when a youth is suicidal. One way of accomplishing this is physically limiting their access to lethal means (sometimes referred to as means restriction or means reduction).

For many individuals, a suicidal crisis is temporary—sometimes as short as an hour or less. If a highly lethal method to kill oneself is less accessible, an individual is less likely to die. Even among individuals who make a Suicide attempt, the vast majority of those who survive do not go on to die by Suicide. Protecting youth from highly lethal means of Suicide attempts is key to Suicide prevention.

What we know:

- More Suicides are completed in the United States with a firearm than by all other methods combined.
- The methods used in Suicide attempts vary widely in how likely they are to result in death, with firearms resulting in death the majority of the time.
- In the United States, the risk of Suicide is two to five times higher in gun-owning homes for all household members, including youth.
- Young people who die by Suicide often use a family member's gun.
- Most studies (although not all) have found that if a firearm is in the home, the risk of someone dying by Suicide is lower when it is stored unloaded, locked, and separate from ammunition.

The issue of reducing access to lethal means, particularly firearms, does not have to involve politics, policy, or gun control legislation. Psychologists can educate parents/caregivers about the dangers of having a firearm in the home and encourage them to remove it if their child is a high risk for Suicide. They can contact their local police station, as many will temporarily hold an individual's firearm.

Stress Among Young People

The most recent American Psychological Association annual survey on "Stress in America" found teens reporting more stress than adults. The most common reported sources of stress in this study were school, getting into a good college or deciding what to do after high school, and financial concerns for their family. A different survey found that in addition to school, teens were also stressed by their parents, romantic relationships, problems in friendships, and younger siblings. In the APA survey, one-third of the teen respondents said they feel sad or depressed, overwhelmed, or lie awake at night due to stress.

Research has found that Suicidal ideation and Suicidal behavior are highest among youth who were *both* victims and perpetrators of bullying. Increases in Suicide risk appear to be similar for victims and bullies regardless of whether they were involved with in-person bullying or cyber-bullying.

Suicide is a complex behavior and is rarely caused by one factor. However, one or more stressors often play a significant role in a teen's suicidal thoughts or behaviors.

Psychologists and other adults in youths' lives should not minimize the stress children and teens experience, assist them when needed, and ensure that young people learn healthy ways to cope—ideally from a very young age.

Elementary-Aged Youth

Our understanding of Suicide among children under the age of 12 is limited due to a paucity of research. However, a study recently published in *Pediatrics* points to some important issues and starting points all psychologists should be aware of.

Children aged 5-11 who died by Suicide, were more likely to:

- ➢ Be boys
- ➢ Be African-American
- ➢ Die by hanging/strangulation/suffocation
- ➢ Die at home
- ➢ Experience relationship problems/arguments with family members

These children were less likely to leave a Suicide note. A current mental health problem was observed in one-third of the children who died by Suicide. Surprisingly, a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) was more common among this young group than a diagnosis of Depression. Tragically, only one-third of the children told anyone about their Suicidal thoughts, feelings or intentions before taking their own lives.

Psychologists play a key role in reducing the number of tragic youth Suicides. California has recently become the seventh state in the country to require that all licensed psychologists be

trained in Suicide risk assessment and intervention. However, many youth who kill themselves are not being seen by (or may never have been seen by) a psychologist. Therefore, we must ensure that all adults raising, teaching, treating, coaching, and interacting with young people recognize youth at risk for Suicide and know who and how to refer them for help. Peers need to know how to recognize the warning signs in their friends and be encouraged to reach out to a trusted adult for assistance.

Most youth suicides are preventable. We know more now about the assessment and treatment of Suicidal thoughts and behaviors than ever in history. Psychologists can take the lead in forming a more responsive safety net for children and teens experiencing unbearable emotional, psychological or situational pain. It is, quite literally, a matter of life and death.

How Community-Based Mentoring Supports a Wholesome Path for Adolescent Growth in At-Risk Boys: A San Diego Success Story

by Kiefer Rich, LMFT

In San Diego, 49,937 boys are growing up in fatherless homes. These boys are at a higher risk of educational failure, gang participation, and incarceration. Seventy percent of youth in state institutions today are fatherless. These boys show signs of unresolved trauma, anger, and frustration. Early intervention is crucial in rebuilding positive academic and behavioral habits and a healthy, sustainable lifestyle. Because at-risk youth are more likely to experience failure in school or drop out entirely, schools and providers continue to look for effective interventions for school-related problems affecting them. This is a critical community need.

The purpose of the innovative Boys to Men Mentoring program is to empower fatherless and at-risk teenage boys to follow their dreams. This is done by facilitating weekly, in-school mentoring groups consisting of other boys, volunteer mentors, and staff facilitators, and encouraging emotional wellness through the development of positive decision-making skills. Group meetings are designed to build trust allowing boys to express themselves without fear of judgment. At the end of the program, boys will have been given the tools to (1) make healthier life decisions, (2) use positive coping skills, (3) be self-accountable and responsible, (4) set realistic goals and work to achieve those goals, (5) effectively and positively engage with others, (6) understand the consequences of their actions, and (7) seek help from others when they are unable to handle problems on their own.

BTM's mentoring program is person-centered, allowing each boy to individually address his behavioral health needs and challenges him to learn how to articulate these needs, therefore making him directly responsible for the healing and help he receives. Each boy's decision-making is self-directed, and the program's curriculum is designed to allow him to articulate his decisions and evaluate the consequences of the actions he makes with the other boys, mentors, and staff facilitators present. The program is open to boys, aged 12-17 years. Currently, most participating boys are 12-14 years old, a critical transitional age for forming lifelong habits,

relationship skills, and goals.

One of the most important tenets of BTM is that mentors do not tell the boys what to do, but instead, share with them their own feelings when they were teens, their mistakes and the lessons learned, and the consequences of their actions. This approach encourages the boys to tell the truth about their own challenges, make their own decisions on how to deal with those challenges, and take responsibility for their choices and the consequences of their actions. BTM trains mentors to listen to their instincts and take action if they feel that the boy needs additional support to meet his goals. The program is designed to create a safe space for boys to openly express themselves without the fear of judgment. Staff facilitators are also trained to (1) identify healthy behavioral habits, (2) know the general stages of adolescent development, (3) utilize group dynamics and effective communication skills, (4) employ cultural awareness in group discussions, (5) understand tribe mentality, (6) utilize active listening skills, and (7) understand BTM policies/procedures and mandated reporter obligations.

The weekly mentoring provides boys with caring, male mentors and rewards their success with positive affirmation. Without positive male role models, boys struggle to develop emotional maturity. For many of the boys, the meetings can be the first time they witness men being open and honest. This exposure enables boys to develop more positive decision-making skills by learning how to analyze their choices and assess the consequences of their actions. The ultimate goal is for each boy to prioritize his emotional and mental wellness. To reward participation and improvement, boys are invited to Adventure Mountain Weekend, a transformative, weekend camping experience. Boys are engaged in emotional development activities and a rite of passage that encourages self-reflection and exploration. Boys often shed tears as they relinquish years of anger, gaining greater clarity, and self-confidence. Through these critical breakthroughs, the boys are supported with a community of staff, mentors, and peers.

In September of 2013, the Caster Family Center for Nonprofit and Philanthropic Research at the University of San Diego conducted a case study using a wide variety of methods to collect and analyze data to evaluate the extent to which BTM's goals had been achieved. Over the years, BTM has formed several collaborative relationships with middle and high schools, and the study focused on the participants of the most established middle school site. The participants of this study included individuals from both within and outside the BTM organization. From within BTM, three administrators (including a program founder), five volunteer mentors, eleven parents, and twenty-three boys (ranging in age from 12-15 years) participated in this qualitative research study.

The research questions that guided the study were as follows: (1) How does the collaboration function? (2) What is the impact of the collaboration on participants? (3) To what extent are the goals of both organizations, schools and BTM realized?

While this study elucidated several of the structures and workings of the collaboration,

it also documented the effectiveness of the BTM mentoring approach. Many of the boys within this study were coping with multiple compounding risk factors. These same risk factors, i.e., poor academic performance, truancy, frequent disciplinary actions in school, and aggressive and defiant behavior, appear to be related to school drop-out, suspensions or incarceration. The case study findings indicated that program participants were able to improve academic performance, behavior, and relationships with adults. This study not only gives hope for the future of fatherless or at-risk boys, but also underscores the urgent need to implement similar partnerships and programming within other high risk schools. The study investigators conclude with a strong recommendation to invest in the further development, research, and evaluation of the BTM organization and its partner schools.

With regard to the three specific research questions, the findings of the study concluded the following: (1) The BTM organization provides the school with increased resources that aid participants in improving their overall success in and out of school. 100% of parents strongly agree BTM is a good thing for their son. (2) Improved grades, increased attendance, and school engagement show that BTM positively influences student behavior. There are less high-level infractions at school, boys report being happier, have a more positive outlook on life, have improved self-esteem, and engage in less risk-taking behavior. BTM enhances boys' relationships. Students are able to build more friendships, and be more trusting of adults. They are also able to communicate more effectively. (3) Both the school and BTM benefit from maintaining the collaboration. For more details about the study and its findings, please go to http://boystomen.org/case-study/

What does the future hold? BTM is currently running almost fifty weekly meetings serving over 780 teenage boys in the San Diego area. The goal is to continue expanding the program to every school in San Diego County. For over twenty years, BTM has found that creating communities of positive male mentors for a fatherless or at-risk teenage boy to get support, encouragement, and guidance from caring and responsive male adults can drastically change the trajectory of a boy's life.

"We have grieved the tragedy of good boys lost to gang violence, suicide, and drug abuse. We know that every boy wants to be a good man; they just need men to show them the way. We know that all it takes to change a boy's life is a few good men who show up and care." - http://boystomen.org/the-problem/,

Innovative programs for high risk boys which intervene at a critical time in adolescence have been urgently needed to reach out and direct boys to a wholesome and fulfilling life path. Their well-being contributes significantly to our community's health and prosperity, as they are part of the future fabric of society. They are an effective way to disrupt the school to prison pipeline. BTM currently has seventy mentors and mentor recruitment is an ongoing process to fulfill the needs of the community. Meetings typically occur during the day at participating middle schools in North and East County, and the organization has plans to expand into Chula Vista. If you would like more information on the BTM program, or are interested in

volunteering to be a mentor, check out their website.

Inside the Teenage Brain: Interview with Jay Giedd, M.D.

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What has surprised you about looking at the adolescent brain?

The most surprising thing has been how much the teen brain is changing. By age six, the brain is already 95 percent of its adult size. But the gray matter, or thinking part of the brain, continues to thicken throughout childhood as the brain cells get extra connections, much like a tree growing extra branches, twigs and roots. In the frontal part of the brain, the part of the brain involved in judgment, organization, planning, strategizing -- those very skills that teens get better and better at -- this process of thickening of the gray matter peaks at about age 11 in girls and age 12 in boys, roughly about the same time as puberty.

After that peak, the gray matter thins as the excess connections are eliminated or pruned. So much of our research is focusing on trying to understand what influences or guides the building-up stage when the gray matter is growing extra branches and connections and what guides the thinning or pruning phase when the excess connections are eliminated.

And what do you think this might mean, this exuberant growth of those early adolescent years?

I think the exuberant growth during the pre-puberty years gives the brain enormous potential. The capacity to be skilled in many different areas is building up during those times. What the influences are of parenting or teachers, society, nutrition, bacterial and viral infections -- all these factors -- on this building-up phase, we're just beginning to try to understand. But the pruning-down phase is perhaps even more interesting, because our leading hypothesis for that is the "Use it or lose it" principle. Those cells and connections that are used will survive and flourish. Those cells and connections that are not used will wither and die.

So if a teen is doing music or sports or academics, those are the cells and connections that will be hard-wired. If they're lying on the couch or playing video games or MTV, those are the cells and connections that are going [to] surprise.

Right around the time of puberty and on into the adult years is a particularly critical time for the brain sculpting to take place. Much like Michelangelo's David, you start out with a huge block of granite at the peak of the puberty years. Then the art is created by removing pieces

of the granite, and that is the way the brain also sculpts itself. Bigger isn't necessarily better, or else the peak in brain function would occur at age 11 or 12. ... The advances come from actually taking away and pruning down of certain connections themselves.

The frontal lobe is often called the CEO, or the executive of the brain. It's involved in things like planning and strategizing and organizing, initiating attention and stopping and starting and shifting attention. It's a part of the brain that most separates man from beast, if you will. That is the part of the brain that has changed most in our human evolution, and a part of the brain that allows us to conduct philosophy and to think about thinking and to think about our place in the universe. ...

I think that [in the teen years, this] part of the brain that is helping organization, planning and strategizing is not done being built yet ... [It is] not that the teens are stupid or incapable of [things]. It's sort of unfair to expect them to have adult levels of organizational skills or decision making before their brain is finished being built. ...

It's also a particularly cruel irony of nature, I think, that right at this time when the brain is most vulnerable is also the time when teens are most likely to experiment with drugs or alcohol. Sometimes when I'm working with teens, I actually show them these brain development curves, how they peak at puberty and then prune down and try to reason with them that if they're doing drugs or alcohol that evening, it may not just be affecting their brains for that night or even for that weekend, but for the next 80 years of their life. ...

Do you have particular concerns about that period, too, though?

Yes. It's a time of enormous opportunity and of enormous risk. And how the teens spend their time seems to be particularly crucial. If the "Lose it or use it" principle holds true, then the activities of the teen may help guide the hard-wiring, actual physical connections in their brain. ...

Can you describe to me what people used to believe about the brain, actually, very recently?

One of the most exciting discoveries from recent neuroscience research is how incredibly plastic the human brain is. For a long time, we used to think that the brain, because it's already 95 percent of adult size by age six, things were largely set in place early in life. ... [There was the] saying. "Give me your child, and by the age of five, I can make him a priest or a thief or a scholar."

[There was] this notion that things were largely set at fairly early ages. And now we realize that isn't true; that even throughout childhood and even the teen years, there's enormous capacity for change. We think that this capacity for change is very empowering for teens. ...

This is an area of neuroscience that's receiving a great deal of attention ... the forces that can guide this plasticity. How do we optimize the brain's ability to learn? Are schools doing a good job? Are we as parents doing a good job? And the challenge now is to ... bridging the gap between neuroscience and practical advice for parents, teachers and society. We're not there yet, but we're closer than ever, and it's really an exciting time in neuroscience. ... The next step will be, what can you do about it, what can we do to help people? What can we do to help the teen optimize the development of their own brain? ...

There has been a great deal of attention on the early years, and particularly on stimulating the early brain. What do you think of that work and that popularization of that brain science?

There's been a great deal of emphasis in the 1990s on the critical importance of the first three years. I certainly applaud those efforts. But what happens sometimes when an area is emphasized so much, is other areas are forgotten. And even though the first 3 years are important, so are the next 16. And the ages between 3 and 16, there's still enormous dynamic activity happening in brain biology. I think that that might have been somewhat overlooked with the emphasis on the early years. ...

Not so long ago, people were emphasizing teaching little children through flashcards, through particular kinds of mobiles with black-and-white checks on them, playing Mozart. In fact, some states have sent CDs back with new mothers. What do you think of that? Has that been a misinterpretation of brain science?

... We all want to do the best for our children. And what I fear is happening is that we're leaping too far from the neuroscience to such things. I don't think there is any established videotape or CD or computer program or type of music to play that we've shown with any scientific backing to actually help our children.

The more technical and more advanced the science becomes, often the more it leads us back to some very basic tenets of spending loving, quality time with our children. …

What directions is the research taking to explore how we can optimize brain development?

Now that we've been able to detect the developmental path of different parts of the brain, the next phase of our research is to try to understand what influences these brain development paths. Is it nutrient or parenting or video games or the activity of the [child]? Or is it genes? By studying [identical] twins, we can begin to address some of these very basic nature/nurture-type of questions.

For instance, when twins are in the first grade, their parents often dress them in the same clothes. They get the same haircut. It's sort of cute how alike they are. But that's not as cool in high school anymore. And so a lot of the twins as teens in high school start doing different things. The one who was a little bit better in sports may become an athlete. The one who was a little bit better at academics may become a scholar. Or one may turn to music and one to art. But they often have different daily activities.

So we can scan the brains when the twins are young and doing everything very much alike; then we can scan them as teenagers, when they start having different daily activities. This gives us a sense of which parts of the brain are influenced by behavior and which parts by the genes themselves.

We've already got some interesting early data on this. …

[The corpus callosum, the thick cable of nerves connecting the two hemispheres] is also interesting because it changes a lot throughout childhood and adolescence. It's been reported to be different in size and shape in many different illnesses that happen during childhood ... many higher cognitive thought [processes] like creativity and ability to solve problems. So it's been of great interest, especially to child psychiatrists. And what we find is that the size and shape of the corpus callosum is remarkably similar amongst twins ... and [so] seems to be surprisingly under the control of the genes.

But another part of the brain -- the cerebellum, in the back of the brain -- is not very genetically controlled. Identical twins' cerebellum are no more alike than non-identical twins. So we think this part of the brain is very susceptible to the environment. And interestingly, it's a part of the brain that changes most during the teen years. This part of the brain has not finished growing well into the early 20s, even. The cerebellum used to be thought to be involved in the coordination of our muscles. So if your cerebellum is working well, you were graceful, a good dancer, a good athlete.

We now know it's also involved in coordination of our cognitive processes, our thinking processes. Just like one can be physically clumsy, one can be kind of mentally clumsy. And this ability to smooth out all the different intellectual processes to navigate the complicated social

life of the teen and to get through these things smoothly and gracefully instead of lurching ... seems to be a function of the cerebellum.

And so we think it's intriguing that we see all these dynamic changes in the cerebellum taking place during the teen years, along with the changes in the behaviors that the cerebellum subserves.

What would influence the development of the cerebellum?

Traditionally it was thought that physical activity would most influence the cerebellum, and that's still one of the leading thoughts. It actually raises thoughts about, as a society, we're less active than we ever have been in the history of humanity. We're good with our thumbs and video games and such. But as far as actual physical activity, running, jumping, playing, children are doing less and less of that, and we wonder, long term, whether that may have an effect on the development of the cerebellum.

…If the cerebellum is exercised and used, both for physical activity but also for cognitive activities, that it will enhance its development.

... almost anything that one can think of as higher thought -- mathematics, music, philosophy, decision making, social skills -- seems to draw upon the cerebellum. ...

The relationship between the findings that we have in the cerebellum and sort of practical advice or the links between behavior are not well worked out yet. That's going to be one of the great challenges of neuroscience -- to go from these neuroscience facts to useful information for parents, for teachers or for society. But it's just so recently that we've been able to capture the cerebellum that no work has yet been done on the forces that will shape the cerebellum or the link between the cerebellum shape or size and function.

When you look at the recent work that you've done in terms of the frontal cortex, do you see a difference between girls and boys?

Yes. One of the things that we're particularly interested in as child psychiatrists is the difference between boys' brains and girls' brains, because nearly everything that we look at as child psychiatrists is different between boys and girls -- different ages of onset, different symptoms, different prevalences and outcomes. Almost everything in childhood is more common in boys -- autism, dyslexia, learning disabilities, ADHD, Tourette's syndrome -- are all more common in boys. Only anorexia nervosa is more common in girls. So we wonder if the differences between boys' and girls' brains might help explain some of these clinical differences.

The male brain is about 10 percent larger than the female brain across all the stages of ... 3 to 20; not to imply that the increased size implies any sort of advantage, because it doesn't. The IQs are very similar. But there are differences between the boy and girl brains, both in the size of certain structures and in their developmental path. The basal ganglia which are a part of the brain that help the frontal lobe do executive functioning are larger in females, and this is a part of the brain that is often smaller in the childhood illnesses. I mentioned, such as ADD and Tourette's syndrome.

So girls, by virtue of having larger basal ganglia, may be afforded some protection against these illnesses. But in the general trend for brain maturation, it's that girls' brains mature earlier than boys' brains. …

The Myth of Parenting as the Etiology of Eating Disorders

by Erin Parks, Ph.D.

As a clinician and researcher who specializes in Eating Disorders, I often contemplate how to increase awareness of Eating Disorders and what, in particular, is least understood about the condition and those who suffer from it. This thought was predominantly on my mind as Eating Disorder Awareness Week (February 26th to March 2nd, 2018) just wrapped up. A few weeks prior, I had an epiphany in an unlikely interaction that led me to the answer.

I was interviewing an applicant for a clinical position to our center, who, besides having impressive credentials, was kind, funny and thoughtful. In the course of the interview, I told her about our own center and its research focus on neuroimaging and genetics to look at the neurobiological underpinnings of eating disorders. I also mentioned that our center takes an agnostic approach to conceptualizing Eating Disorders, consistent with Family Based/ Maudsley therapy, which is based in the belief that that parents do *not* cause eating disorders. The applicant smiled, met my gaze, raised her eyebrows, and leaned in as though we were about to share a secret, and said:

"I understand why you tell the parents that, but surely you don't *really* believe that."

I *truly* do believe that parents do NOT cause Eating Disorders. I share that belief with our directors, our researchers, our clinicians, our office managers, our dietitians, our cooks, and every last member of our staff. We know that Eating Disorders, like other complex medical and mental health illnesses such as cancer, epilepsy, schizophrenia, and autism, are caused primarily by neurobiological and genetic factors. It is easy for us to refrain from blaming the parents as THE cause of Eating Disorders because we spend our days working with caring and concerned parents who are doing their best to raise happy and healthy children. These parents are shocked that their child has become so ill, because similar tothe interviewing clinician, they too had previously believed that poor parenting caused Eating Disorders.

I wish I could say that was the first time in an interview that someone had asked me if I secretly blamed the parents, but there are many intelligent and caring people—clinicians, teachers, neighbors, friends—who believe the common myth that faulty parenting causes eating disorders. This myth of parental causation has existed for many illnesses and most mental health disorders. For decades, parents, and in particular mothers, were traditionally cited as the primary cause of mental illness in their offspring. In the 1940s, the "schizophrenogenic mother," a mother who was simultaneously rejecting and overprotective, was a popular theory of the etiology of schizophrenia. With greater awareness of mental illness and its genetic underpinnings, the idea that parents cause schizophrenia—or ADHD, autism, depression--has generally (and thankfully) fallen out of favor. Yet, the myth of parental roles in the causation of Eating Disorders continues to prevail. To understand why that is, one must consider the characteristics of Eating Disorders:

Eating disorders have the highest mortality of any mental illness—rates that many studies suggest may be comparable to common pediatric cancers. And yet, when we hear of a child getting diagnosed with cancer, friends and neighbors spend very little time wondering ***what caused*** the cancer and instead energy is focused on ***treating*** the cancer and ***supporting*** the family. The same is not true when a child is diagnosed with an eating disorder.

When I asked a focus group of caring, intelligent parents what thoughts came into their minds when hearing of a 13-year-old being hospitalized for an eating disorder, they confided that they wondered about the parents: did they diet in front of their children; did they pressure them to succeed; did they convey certain messages about body image? There is this cultural sense that there is a right way and a wrong way to raise a child, and doing it incorrectly can cause problems—including eating disorders. So what is the right way?

There is a prolific stream of conflicting parenting articles offering the latest opinion/theory/research on how to approach feeding your family.

Here are just a few examples:

- Don't feed your kids sugar: they'll become addicted vs. Feed your kids sugar: depriving them will make them binge later
- Make your kids try new foods: if not, they'll never develop a healthy palate vs. Don't worry if your kids are picky eaters: they will have disordered eating if you make food a battle
- Don't bribe your kids with food: food shouldn't be a reward vs. You can bribe your kids with food if it helps them eat their vegetables
- Hide vegetables in your kids' foods vs. Don't lie to your kids about what's in their food
- Let your kids eat as much or as little as they want: follow their lead so they become intuitive eaters vs. Your kids should be on a schedule, including meals: structure is good for kids.
- Gluten is bad vs. All food is good
- Kids have to eat meat vs.No, kids should eat meat

- Dieting is bad: teach kids to love their bodies at all shapes vs.Model healthy eating: we have an obesity epidemic
- If you put your kid on a diet they will develop an eating disorder vs. If you don't put your kid on a diet they will become obese and get diabetes

Confused yet?

The conflicting advice continues when the parenting articles discuss achievement. Parents should teach their children art and music and sports and STEM skills and foreign languages. Parents enroll their children in way too many activities. Parents should let their children choose their activities. Tiger Moms vs Free Range Kids. Kumon vs Montesorri. It's your fault if your children get hurt—you should have been watching them. Don't be a helicopter parent and let your children play unsupervised. Challenge your kids, they need frustration and failure —they need grit. Don't push your kids—they'll develop eating disorders.

Parenting is an unyielding stream of decisions, creating infinite iterations of parenting.

Our clinic has worked with hundreds of families and while their home cultures slightly differ, most are just typical families, trying to find moderation amid the sea of conflicting internet advice when it comes to feeding and raising their kids. No matter what food and parenting choices they made for their families, somewhere there is an expert saying that they made the wrong choice and that is why their child has disordered eating.

A confession: I have two toddlers and I consume the endless stream of conflicting parenting articles that fill my Facebook feed and the Huffington Post. Sometimes I WANT parents to be the cause of language delays and college dropouts and cancer and bullying and ADHD and eating disorders. Then I could just parent "correctly" and guarantee that nothing bad will ever happen to the two children I love most in this world. But the reality is that there are pros and cons to all decisions and there are complex causes to complex issues. The reality is that parents everywhere are trying their very best, doing a very good job, and are parenting in ways that may look very similar to how each of us parent—and their children are struggling with difficult and scary things—including eating disorders.

Many articles during Eating Disorders Awareness Week spoke of hypothesized causes of eating disorders, e.g., food culture, focus on achievement, the media, and so forth, and while it can be important to think about the negative consequences of some aspects of our culture, this search for a singular cause can feed into the culture of blaming the parents. The majority of parents will diet, the majority of women will feel bad about their bodies, the majority of teens will feel pressure to succeed, and the majority of images of women in the media will be distorted and unhealthy—and yet the majority of children will NOT develop eating disorders.

I sincerely hope we can turn the conversation to the successful evidence-based treatments that now exist for eating disorders and how we can improve upon them so that treatments are effective, accessible, and affordable for everyone. I hope that we can discuss how parents know

their children best and can be the most wonderful treatment allies in helping their children fully recover from an eating disorder. If I draw awareness to just one thing about Eating Disorders, may it be this: parents are NOT the cause of their children's Eating Disorders and they do not deserve to be blamed.

Part of the Maudsley or FBT approach is to involve the family in treatment. There is strong evidence that children, teenagers, and even young adults heal faster and relapse is prevented, when parents are involved. Parents are critically important, and often provide valuable perspectives on their child to treatment providers. And while parents may not have caused the eating disorder, they may need new skills to fight the eating disorder. When well informed, they can implement important behavioral and emotional components that will support their child's recovery. Perhaps one of the most important lessons in coming together as a family to support their child's eating disorder treatment and recovery is to experience what a resource their family is, as they develop new skills, express their caring for each other, and share the insights they are learning in response to this challenge. Not only may their child recover from the Eating Disorder, but all family members may grow, thrive, and develop new strengths in unexpected ways.

genome of a generation in healing

poem *by* Maya Salameh

I will piece myself back together by
the crux of entwined lashes
at the apex of my eyes
where memories meet mind
and mind mars memories.

I will domestically consolidate my
assets with the bindings
of my dna; the weak hydrogen
bonds and the supplement vitamin-gummy strong of family. the nitrogenous bases
of my internal faraway can't-confiscate-conceal-or-carry
places. I will laugh
and reunite my peddling
provinces under an iron fist. I will explore
the solar systems under my tongue.
I have reconciled with myself two, ten, twelve times before.
there is a terrible
beauty in loving your rocky
beaches. the coast is only complete with
its jagged pieces.

I will make peace. I will post
memos on my hipbones to remind
me of the power in my curved unnerved lips.

I will paint polished truths onto my toes.
I will draft legislation up and down my legs.
I will welcome every imperfection/scar/flaw -
love will be the highest law.

I will reunite in all of my languages.
me reuniré
je me reunirai
saatahed.
I will pray. incense is always burning somewhere.
this is worthy of worship.

I will barter my palms for poems painted in persimmon.
many have called me a poet, but I'm still becoming a writer, I am still working on my intimacy.

I will feel like a phenomenon - cold front staining shoulders, cumulus crowding curls, lightning between lips.

when asked about innocence, I will answer my sister and I spent night after night wishing on the flimsy stars stuck to our ceiling. sometimes, intention glows better in the dark.

when my bones shake with the gravity of all that is left to be done,
I will remember some things
are still worth our awe, some things
are still worth blood and ink, still worth taking stock and keeping score,

some things
are still worth falling for.

so I will speak -
before it swallows me.

when they tell you not to take that tone. remember. for every goliath there is a stone.

I resolve for the new year to write an essay. I will call it home.
I will write a story. I will call it grief.
I will write a poem. I will call it relief.

Learning to Surf

poem *by* Mary Mulvihill, Ph.D.

The yellow board is taller
than she is. Her father
lugs it thru the water's
white lace, into
shallow shorebreak,
waist high. They shoulder
oncoming breakers. Wait
for a wave the right size.

Between sets, he flips
the board toward shore -
her signal. She flops on.
He pushes – the swell shoots
her forward. She skids
onto her knees. Lifts
her bum. Crouches, still

clutches the board's tip,
bent double. Slowly, stands
just as the board runs
aground In the soft sand,
out of ocean. This goes on
for an hour. She imagines
herself flying
through the tube. Slips.

Is whomped. Bobs up.
Fetches the board. After
a while, her body
takes over. Enjoys
the little glide so much,
she forgets clumsy. Is
lifted into flow. Balances.

Finally

rides all the way in. Leaps
off, elated. Dances
in the kelp. Her father shares
the joy. Poignantly
releases a little part of her. Knows
from this day forward
she's betrothed
to the sea.