

Letter to The Editor:

Is there bias in the criteria used to judge submissions to the 2005 AACAP conference?

Dear Editor,

I would like to express my deep regret in the evaluation process by which conference organizers decide what “makes it” into our upcoming Academy meeting (Toronto Oct 18-23, 2005). I had submitted two proposals, one in a poster format concerning my work on the magnetic resonance imaging spectroscopic findings on hyperkinetic disorder in children (DSM-4 TR, ADHD combined subtype) and a workshop proposal about the application of narrative therapy in child psychiatry. The former submission was accepted but the latter was rejected by the evaluation committee because it was not “evidence based” ie the narrative approach is not supported by random controlled trials (RCT’s) or meta-analyses.

Has the obsessive focus for “evidence” at any cost by a select group of committee members eclipsed our rich tradition in synthesizing art and science in our beloved field? When has this become official AACAP policy? In Hamilton’s inaugural column about Evidence-Based Practise (2005, this journal) he states, “A clinician needs good judgement and considerable skill to craft an intervention based on both evidence and a specific family’s values and preferences.” Are we giving lip service to the complexity of clinical decision-making since only a part of this can be evidence based?

Both inside and outside medicine there have been trenchant criticisms of evidence based medicine (EBM) as the “Emperor’s Clinical Epidemiology dressed in new clothes” (Charlton 1997). He questions the validity of epidemiological type data favored in EBM as not providing the total information necessary to treat individual patients. In his critique of meta-analysis as method, meta-analytic studies derived from the creation of a virtual study based on an unrepresentative meta-protocol and meta-population have no generalizable meaning to the individual patient. According to Sackett (1996) EBM involves tracking down the best external evidence with which to answer our clinical questions. Cross-sectional studies are best to study the accuracy of diagnostic tests in populations suspected of harboring the disorder whereas follow-up studies of patients assembled at a uniform point in time early in the clinical course of their disease are more suitable for prognostic questions. RCT’s are reserved for treatment protocols to control for experimenter bias. RCT’s and meta-analytic studies are at the top of the evidence chain as opposed to more observational or case-based evidence but results from RCT’s may appear paradoxical (ie point in different directions) and weaker than strong observational studies (Guyatt et al 2000). Paradoxically while RCT’s and systematic reviews are “the gold standard” such data must always be subordinated to clinical expertise in clinical decision making (Sackett 1996).

Narrative Therapy (White and Epston, 1990) while becoming increasingly popular with practitioners in non-medical fields, has been strangely neglected by child psychiatrists. It is an approach that is inherently qualitative and philosophically rejects quantifying children (and individuals) with labels and tests. It privileges looking at the individual attribution of meaning behind life events or significant relationships. Narrative practitioners privilege the client’s voice, his/her wisdom through lived experiences and work collaboratively with the client. Child psychiatrists could gain valuable insights into their clients’ experience through a narrative approach complemented by evidence based practices.

In my work with spectroscopy and imaging, even though at the meeting I would have presented neurometabolite levels and statistical levels of significance and hence convey the aura of “objective evidence”, the art of spectroscopy still demands that I make a subjective judgement as to what counts as high quality spectral profiles since at one point the line between signal and noise becomes quite blurred. There is inter-rater reliability but much of this is based on acquiring an “eye” for the patterns.

Psychiatry in the past has fallen into the false dichotomy trap of the brainless or the mindless. Now the battle lines appear to be drawn (once more) between the “objectivists” and the “subjectivists”. While I am not advocating that “anything goes” for theory or therapy, I do not think our field will ever escape (nor should we want to) a certain professional artistry not amenable to evidence. The workshop we were potentially offering, while not evidence based, nonetheless represented the cumulative experience of seasoned narrative therapists, collated into a book soon to be published by a leading academic press. As a result of the committee’s decision, I cannot ethically present one type of findings at the meeting while ignoring the other especially if there are no fora where these issues can be debated.

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Response to the letter to the Editor

Thank you for the opportunity to respond to Dr. Carrey's letter. We also appreciated meeting with him on-site at the meeting in Toronto to discuss his concerns.

The Joint Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP) and the Canadian Academy of Child and Adolescent Psychiatry (CACAP) took place October 18-23, 2005 in Toronto, Canada. With a total of 3,541 attendees, including 405 Canadians and 727 International attendees, this was the largest meeting ever for both organizations.

The incredible interest in the meeting was also represented by the increase in submissions. We received 749 submissions for the Joint Annual Meeting *Call for Papers*, representing over a 40% increase from 2004. The overall acceptance rate was 55% compared with 72% in 2004. The Program Committee (PC), including representatives from the CACAP, had the enormous task of selecting the final program.

To help readers better understand AACAP's PC process, we will outline our procedures. The *Call for Papers* is distributed each October for the following year's Annual Meeting. It is revised annually based on feedback from our members. For the February submission deadline, each proposal is reviewed by at least 5 committee members, including the PC Chair and Deputy Chair. Each submission is also discussed by the entire committee at the April meeting. Particular care is given to whether the submission fits the format requested. Although we try and adjust submissions to other formats if appropriate, choosing a less appropriate format hurts the submission. Each submission is placed in one of three categories: "accept", "reject", or "revise and resubmit (R&R)." Only presentations that would be appropriate to be resubmitted for the June New Research Poster deadline receive the "R&R" designation. Currently this is the only group that will receive feedback from the committee on ways to improve their submission. There is no "R&R" for worthy, but not selected submissions that would not be appropriate as a poster format.

After the selection process, the Chair and Deputy Chair "put the program together" by assigning the selected submissions to time slots. This provides an opportunity to look for both topic diversity and clinical versus basic research diversity. At this time some highly rated, but not previously accepted submissions may be added to the program.

The debate about balance in the program has been ongoing for as long as any of us can remember. For the Toronto meeting, a new submission format, "Clinical Perspectives" was instituted just for that reason and the number of Clinical Case Conferences and Clinical Consultation Breakfasts were increased over previous years. A major goal of the AACAP Program Committee (PC) has been to continue an open dialogue on the issue of balance. As a result, the new PC Chair (Harmon), Deputy Chair, (Leventhal) and Meetings Department Director (Fordi) have met with AACAP components (committees and work groups) and individuals over the last two years in an effort to get feedback about this issue and to guide submitters as to how their work best fits the different PC formats (clinical case conferences, clinical perspectives, institutes, posters, symposia, etc.). At the meeting in Toronto, we met with three components, and members of the PC committee met with several more as liaisons or ad hoc committee members. We also met with Dr. Carrey to discuss his concerns. We hope that discussion was useful for him.

With regard to Dr. Carrey's submission, the difficulty with the submission was not the topic, e.g., "narrative therapy" but the request for a workshop. Workshops are presentations designed to "teach" clinicians a particular approach; as part of a "hands-on, focused learning experience." The PC wants to be sure that the validity and utility of the approach that is taught has been well documented by some type of evidence which

can range from peer-reviewed literature on the topic to well-controlled studies. The scientific evidence and the limitations of the technique or approach need to be presented. In the case of the “narrative therapy” submission, had the same topic been part of a clinical perspective or clinical case conference (or part of an Institute presentation), which does not set out to “teach” clinicians a particular approach, different criteria would have been used to make a decision about it. Given the existing time lines, unfortunately we did not have an option to suggest a resubmission in another format.

Each year the committee reviews all the evaluations from the previous year’s meeting including specific presentations as well as overall impressions. These evaluations will be available in December. Although anecdotal, specific positive feedback about a “balanced program” was provided to the PC leadership at the Component Chair’s Meeting, AACAP Council Meeting and the AACAP Business Meeting as well as by individuals throughout the meeting.

Sincerely,

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