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Welcome to JAACAP Connect!

What is JAACAP Connect?
All are invited! JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of JAACAP Connect is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need JAACAP Connect?
The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. JAACAP Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

Who reads JAACAP Connect?
All students, trainees, and clinicians who are interested in child and adolescent mental health will benefit from reading JAACAP Connect, available online at www.jaacap.com/content/connect. AACAP members will receive emails announcing new quarterly issues.

Who writes JAACAP Connect?
You do! We seek highly motivated students, trainees, early career, and seasoned clinicians and researchers from all disciplines with compelling observations about child and adolescent psychiatry. We pair authors with mentors when necessary, and work as a team to create the final manuscripts.

What are the content requirements for JAACAP Connect articles?
JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our first edition, the topic and format can vary widely, from neuroscience to teen music choices.

How can JAACAP Connect help with my educational requirements?
Motivated by the ACGME/ABPN Psychiatry Milestone Project©, JAACAP Connect aims to promote the development of the skillset necessary for translating scientific research into clinical practice. The process of science-based publication creates a vital set of skills that is rarely acquired elsewhere, and models the real-life thought process of translating scientific findings into clinical care. To bring this experience to more trainees and providers, JAACAP Connect aims to enhance mastery of translating scientific findings into clinical reality by encouraging publishing as education.

JAACAP Connect combines education and skill acquisition with mentorship and guidance to offer new experiences in science-based publication. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles. Opportunities for increasing knowledge and skills through publishing as education will be available through continued contributions and direct involvement with the JAACAP Connect editorial team, using an apprenticeship model.

Start Thinking About Authorship With JAACAP Connect
What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate. All are welcome, and you are invited.
We Cannot be Silent: Using Our Voice to Be Anti-Racist

As I began writing this introduction, a piece typically meant to tie the various Connect articles together, I reflected on the stark changes in our country since authors began writing their articles for this issue. First, a pandemic brought substantial change to the overall mental health of the country, including the way that psychiatric services are provided, accessed, and taught. The changes that COVID-19 has brought to the state of mental health in the country and the way that psychiatric services are provided and taught has been a whirlwind that nobody was prepared for. COVID-19 further exposed the racial disparities in services due to systemic racism that have existed long before the pandemic, leading to significant differences in the morbidity and mortality of the illness towards people of color. In addition, the killings of Black men and women exemplified in George Floyd having his breath taken from him, Breonna Taylor shot while sleeping in her home, and Ahmaud Arbery shot while simply jogging, awoke the need to identify the systemic racism that is, and has been killing Black people. As child and adolescent psychiatrists, we see the impact of racism daily in the lack of access to services, the difference in treatment provided to children in school, and the fear and anxiety that Black youth and parents experience doing what should be mundane tasks because of the potential life-changing consequences. We are taking the following initial steps to change our journal.

It is with great humility that we acknowledge our failure as editors in ensuring these issues receive the coverage and discussion they deserve. As editors, writers, and readers, we can no longer be silent bystanders to racism. We must take an active stance to be anti-racist. As an editorial board, we are working with our colleagues at JAACAP and are in the process of identifying the steps we need to take to ensure that our journal is no longer a part of the problem and that we are instead changing the way scientific writing and editing occurs. We acknowledge that this is a work in progress for the foreseeable future.

To start, JAACAP Connect is a journal intended to be available for writers at all levels to start the process of writing. The papers and ideas we receive often do not reflect the diversity of our profession and our patient population, so we will actively solicit articles from diverse authors and encourage anyone reading this to reach out to start the process of writing. We also know that to really strive to be anti-racist, we recognize the need to diversify our editorial board, so we ask anyone interested in editing to reach out and we will be actively working to identify editors.

JAACAP Connect will also have 2 upcoming themed issues, the first on COVID-19 and the second on systemic racism, which will include an examination of systemic changes that need to occur to change current practices. For the issue on systemic racism, we will feature a guest lead editor, recognizing the importance of bringing in an expert in the field to ensure that as an editorial board, we are taking steps to be anti-racist in our editorial work. We will also have a continued call for papers on systemic racism, beyond just this specific theme issue.

When writing, authors will be encouraged to think critically about how racism might have had an impact on the topic. For example, when looking at differences in outcomes related to race, we can consider the impact of racism, rather than race, on differing outcomes and what can be done to address this disparity. As editors we will develop guidance questions to improve our approach and our reviews by remaining conscious of racism.

We need to do better, and as writers, editors, child psychiatrists, and physicians, we must use our powerful voice and respond to our duty to actively address racism. And we need your help. We want your feedback, your writing, and your help in editing. We look forward to hearing from you at connect@jaccap.org.

Justin Schreiber, DO, MPH
Editor
Lab to Smartphone

How Psychiatry Residencies Became Competitive Again

Christopher Chamanadjian, MD, and David Rettew, MD

When I started medical school in 2014, the field of psychiatry was considered a “layup” residency to match into. I recall one professor saying, “You all must excel in your academics to give yourself the best chance in matching, because it is incredibly competitive—unless you want psychiatry.”

Don’t look now, but psychiatry is becoming one of the more competitive categorical residency programs. In the past 5 years, matching in psychiatry “increased both modestly and consistently”.1 The National Residency Matching Program (NRMP) reports that in 2016, the proportion of total US seniors matching into psychiatry was 5.0%.2 In 2020, the proportion increased to 6.3%. Furthermore, the number of positions offered in psychiatry continues to steadily grow each year. In 2020, psychiatry positions offered (1,858) was the highest recorded and represented a 34.2% (474) increase from 2016 (1,384) and 74.0% (789) increase from 2008 (1,069). What might be behind this increased popularity of psychiatry? Nobody knows for sure, and different people obviously choose the specialty for different reasons. Here, however, are a few of the possibilities.

Prevalence. The Centers for Disease Control and Prevention estimate that approximately 1 in 6 US children has a mental, behavior, or developmental disorder.3 A recent report by the American Psychological Association estimates a 71% increase in adolescents experiencing serious monthly psychological distress from 2008 to 2017 (an increase from 7.7% to 13.1%).4 As the prevalence increases, so does the likelihood of knowing someone suffering from a mental health condition. This increase in the number of struggling youths is attracting increased media attention and may be inspiring some medical students to answer the call.

Neuropsychiatric Research Advancements. For centuries the mind was a longstanding mystery in medicine. However, recent discoveries continue to unveil previously unknown neurobiological complexities contributing to mental health. Neuroimaging, brain mapping, and genetic sequencing research studies reveal key insights into the neurophysiologic processes underlying many psychiatric disorders. Alongside other related medical fields, such as sleep and pain medicine, we continue to understand the multiple factors affecting psychiatry. As we slowly unravel some of the mysteries of our “home” organ, psychiatry’s parallels with other specialties becomes more apparent.

Reduced Stigma. Mental health stigma remains a significant problem but has been falling, thanks in part to social media. With the emergence of innovative communication technologies, we enter an era of unprecedented access to people. From celebrities to key public figures, social media has provided a platform for many people to openly share their personal struggles with mental health. Some pop culture influencers have also deliberately aimed to break the stigma in specific campaigns such as #YouAreNotAlone. These efforts have demonstrated how common mental illness is in the United States. Through the use of hashtags, public figures, and nationwide campaigns, social media helped spread the importance of mental health to millions.

Work-Life Balance. Psychiatry can bring a healthy balance between work and lifestyle. The work environment of psychiatrists can include an office setting with regular working hours, fewer emergencies, and less on-call obligations, although recent events with COVID-19 have shown that these qualities are not guaranteed. Nevertheless, this schedule allows more time for family, hobbies, or any non-work activities which in
Quality of life is becoming a growing priority for students choosing a medical specialty.

**Physician-Patient Relationship.** The physician-patient relationship is a sacred partnership. However, the current healthcare system overwhelms physicians with paperwork, billing literacy, and documentation. I fell in love with medicine for the connections between the physician and the patient. But now, the overwhelming logistical duties sacrifice time spent conversing with the patient, requiring attention to their electronic documentation instead. While psychiatry also struggles with these encumbrances, the true art of medicine still lives. Spending more time getting to know your patient, a psychiatrist can use their knowledge and authentic communication to not only understand the diagnosis but more so the human being sitting across from them.

**Job Opportunity.** Psychiatry career opportunities are wide and various. There has remained a persistent disparity between decreased supply of psychiatrists and increased demand of mental health services. The National Institute of Mental Health (NIMH) reported only 7.5 of the 11.2 million (66.7%) of US adults suffering from serious mental illness received necessary services. As a result, employment opportunities are abundant in both rural and urban areas. Regarding specialization, numerous psychiatry fellowships offer subspecialties in addiction, child and adolescent, forensic, geriatric, liaison consulting, and many more. With so many branches to choose from, each psychiatry resident is more likely to find their niche interest.

**Integrative Medicine.** It is increasingly clear that mental health is a foundation for general health, and how your body influences your mental health and vice versa. Maintaining a healthy diet, getting regular exercise, and practicing meditation all improve one’s physical and mental health. As these bidirectional influences become more and more apparent, the value of psychiatrists and other mental health professionals in healthcare settings of all kind is being fully appreciated with there being growing opportunities for collaboration.

Because of these factors, and others, psychiatry is now in much more demand. While this may lead to some extra challenges for those wishing to enter the field, such a shift is a positive development both for those doing psychiatric work and the people whom we serve.

**References**

About the Authors

Christopher A. Chamanadjian, MD, is a recent medical school graduate from St. George’s University School of Medicine, Grenada, aspiring to pursue psychiatry. His interests include child and adolescent psychiatry, healthcare innovation technologies with digital therapeutics for mental health, artificial intelligence, integrated behavioral healthcare, and student mental health. He is a member of the AACAP regional organization Southern California Society of Child and Adolescent Psychiatry and several APA caucuses including the College Mental Health and Integrative Psychiatry Caucus.

David C. Rettew, MD, is an associate professor of psychiatry and pediatrics at the University of Vermont Larner College of Medicine and the Medical Director for the Child Division of the Vermont Department of Mental Health. He is author of the book Child Psychiatry: New Thinking About the Boundary Between Traits and Illness and the “ABCs of Child Psychiatry” blog on the Psychology Today website. You can follow him on Twitter at @PediPsych.

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Disclosure: Dr. Rettew has received royalties for his blog for Psychology Today and from Guilford Press. Dr. Chamanadjian has served as Sr. Medical Science Liaison & Medical Affairs Consultant at Cognoa, Inc.

Correspondence to Christopher Chamanadjian, MD; e-mail: chrischama@gmail.com

To Participate in the Lab to Smartphone Column

To suggest a topic for this column or to inquire about co-writing a Lab to Smartphone column with Dr. Rettew or another child psychiatry mentor, please send an email to david.rettew@med.uvm.edu.
What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP's Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Anticipating the Mental Health Effects of COVID-19 in Youth: Social Isolation in a Digital Age

Kyle Rutledge, DO, PhD

We have entered unusual times. As of this writing, the pandemic of COVID-19 is continuing to grow exponentially. New cases arise, policy changes quickly, and the entire world has become unified against a common enemy. In the United States, schools have been closed, recreational gatherings cancelled, and states locked down. Within medical education, students have been pulled off rotations, residents and attending physicians have found themselves reassigned to “the front lines,” and clinics have begun more liberally adopting telehealth systems. Social media is buzzing about the disease, with videos of quarantine-inspired novelties, memes cataloguing fears and reactions, and several posts even questioning the legitimacy of the threat. In psychiatry, we find ourselves working to anticipate how the fallout will land in the realm of mental health, and questioning what we can do about it.

Attempts to predict and mitigate negative outcomes of the pandemic may be informed by prior pandemics as well as literature of “disaster mental health,” a branch of research which delves into the psychological outcomes of large-scale catastrophes. While this field often focuses on the effects of regional natural disasters such as earthquakes, tornadoes, and floods, the themes apply to pandemics as well. This research has shown there to be an increased incidence of certain mental health diagnoses following disasters, including posttraumatic stress disorder, major depressive disorder, and generalized anxiety disorder. Some subpopulations have been found particularly vulnerable, including individuals with low socioeconomic resources, substance use issues or premorbid mental disorders, and children. Therefore, it is fair to anticipate the development of more psychiatric illness during the current pandemic, with some individuals at greater risk than others. Considering this risk in our own patient populations, a first step is to evaluate each of our patients with respect to their own responses and experience with COVID-19, paying special attention to our more vulnerable populations.

Currently, there are no formal, standardized assessment tools available that would allow us to systematically determine who may face the greatest psychological impact from a pandemic. However, the themes of the Psychological Preparedness for Disaster Threat Scale (PPDTS)—created to assess the response to the cyclones in Australia—may be extrapolated for use in evaluation of COVID-19 response. Psychological preparedness, as operationalized as a score on the PPDTS, is related to mental health through the course of disaster experience and response. The themes of the questionnaire may be simplified into 3 parts: 1) insight into one’s own psychological response to the event, 2) capacity and confidence to psychologically and socially cope with this response, and 3) ability and confidence in managing external effects of the situation. Therefore, our own open-ended assessments of how individuals may be mentally responding to COVID-19 may include questions to gauge the individual’s perception of their own internal response, any coping skills they utilize (in particular if they are turning to alcohol or substances), and to what degree they feel hopeless or in control regarding their role in the current pandemic. Based on our own clinical judgement as we gather more information, it may become clearer which individuals are struggling more than others with the pandemic and may require an increase in services and closer follow-up.

In the case of assessing children and adolescents, we must pay particular attention to the many ways the family may have been disrupted by the pandemic. Effects of COVID-19 impacting the family are not only limited to contracting the illness, but may also include: occupational stressors, marked alteration to routine of child supervision, decreased access to medical...
care for family members and children, and difficulty acquiring goods and home essentials. While a child may be in tune to these changes, these stressors can also lead to indirect effects through the response of family members. Evidence from previous disasters indicate that these pandemic-generated woes may elicit maladaptive responses from caregivers or other members of the home, which could lead to deterioration of a caregiver’s own mental health or increased alcohol or substance use. During prior economic crises, multiple correlations have been found which link unemployment, debt, and difficulty with housing payments to alcohol use, family violence, child maltreatment, and neglect. Accordingly, with other pandemics, there have been reports to suggest school closures may lead to increased reports of child abuse. While the family may be a source of strength and support for a child during a global crisis, we must also be aware of the many ways new stressors in the family can negatively impact the child in this pandemic.

Outside of the immediate family, it is important to note the additional threat on mental health that comes with social isolation during quarantine and associated over utilization of social media. Brooks et al provide a timely piece regarding ways to reduce the psychological impact of quarantine and social distancing specifically. Among the authors’ suggestions for mitigation of risk from quarantine is ensuring ongoing access to information, improving communication, and reducing monotony. Further advice that may be especially important for adolescents is praising the altruism of choosing to keep others safe through quarantine, while taking the focus off the loss of liberty from mandated sequestration. Although children and adolescents have been restricted from physically interacting with friends or large groups, their phones, tablets, and other screens allow them to continue to socially and emotionally connect with friends and family on a daily basis. Also, with social media, the population is able to commiserate through their similar experience in real time, perhaps reducing the sense of loneliness. However, social media access during social isolation does not come without risk. It has also been found that negative experiences on social media are associated with higher perceived social isolation, while positive experiences do little to decrease these feelings. These findings underscore the importance of balancing social engagement online to limit over-exposing oneself to negative or deceptive social media.

The magnitude of impact of COVID-19 each individual faces will differ, with some children and adolescents at higher risk than others and therefore requiring different responses. For those facing a milder form of distress, practices including reassurance, normalization, and recommendations for stress reduction may be sufficient. When patients share feelings, we can validate them and help them challenge any cognitive distortions exaggerating the assessment of risk by a patient. We may direct our attention to reducing stress in the family and home, while promoting resilience practices in all children and adolescents. Some suggestions may be generalized for most patients, such as maintaining routines and limiting exposure to stress provoking pandemic-related media, intentionally setting aside time for relaxation, and promoting mindfulness and positive thinking. We may direct patients to resources and recommendations from the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) as summarized in Table 1. For individuals facing more significant distress and impairment, these practices remain appropriate, but may be insufficient, and increase in offered services such as more frequent therapy and follow-up may be necessary. Individuals in more acute scenarios undergoing such stress may benefit from Psychological First Aid, a manualized approach to disaster response in children to foster short-term and long-term adaptation to trauma. The practice includes steps of engagement, providing safety and comfort, stabilizing overwhelming emotions, sharing resources for practical assistance with immediate needs, providing information on coping, and connecting to collaborative services and social supports.

The role of the child psychiatrist at this time of uncertainty remains at its core focused on improving patient care. During COVID-19, beyond our typical duty to
conduct assessments and manage treatment plans, we may also begin addressing concerns as they arise related to the pandemic while we anticipate more to come. A comprehensive assessment of the child or adolescent during a pandemic would include questions into the psychological preparedness, social and behavioral consequences on the family, prior mental health status, illness threatening life of the self or a family member, bereavement, separation from family, and socioeconomic status. Questions on the perceived personal effects of COVID-19, coping behaviors and ability to adapt, as well as effects on members of the household can be incorporated seamlessly into evaluations of patients in order to uncover higher risk individuals and inspire targets for management. Balancing use of social media to mitigate social isolation and maintain connections without over exposure to negative experiences stands as a challenge to our patients that should not be underestimated, and an area to explore during patient encounters. Beyond the patients we see daily, we may also disseminate basic information promoting mental health in patients for front-line medical workers to share with patients as well, reaching a greater number of individuals. The recommendations from the CDC and WHO for decreasing stress during this time may also be circulated to patients and families, shared in offices, or posted in common areas of medical centers. Finally, we must not underestimate the power of every action to stop the spread of the illness, including informing parents about safe practices, as marginal reductions in the disease burden of the pandemic will translate to decreased risk for mental health sequelae.

Table 1. Summary of Recommendations From the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO)^13,14

<table>
<thead>
<tr>
<th>Domain</th>
<th>Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Physical health</td>
<td>Schedule well balanced meals</td>
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<tr>
<td></td>
<td>Maintain sufficient sleep</td>
</tr>
<tr>
<td></td>
<td>Prioritize regular exercise</td>
</tr>
<tr>
<td></td>
<td>Avoid alcohol and other substances</td>
</tr>
<tr>
<td>Routines</td>
<td>Keep consistent sleep and wake times</td>
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<tr>
<td></td>
<td>Maintain personal hygiene</td>
</tr>
<tr>
<td></td>
<td>Structure time for both work and rest</td>
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<tr>
<td></td>
<td>Set aside time for enjoyable activities</td>
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<tr>
<td>Relaxation</td>
<td>Practice deep-breathing exercises</td>
</tr>
<tr>
<td></td>
<td>Practice stretching</td>
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<tr>
<td></td>
<td>Practice meditating</td>
</tr>
<tr>
<td>Information</td>
<td>Stay informed on the pandemic</td>
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<td></td>
<td>Know where and how to get treatment</td>
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<tr>
<td></td>
<td>Avoid over-exposure to the news</td>
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<td></td>
<td>Take breaks from social media</td>
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<tr>
<td></td>
<td>Correct misinformation when encountered</td>
</tr>
<tr>
<td>Connections</td>
<td>Connect with individuals for emotional support</td>
</tr>
<tr>
<td></td>
<td>Connect with community and faith-based organizations</td>
</tr>
<tr>
<td>Help</td>
<td>Offer help to others</td>
</tr>
<tr>
<td></td>
<td>Seek help when needed</td>
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Take Home Summary
COVID-19 will leave a lasting impression on our youth. This article applies lessons from disaster mental health literature and prior pandemics to anticipate child and adolescent mental health struggles, and shares suggestions for patient interactions during the pandemic.

References
About the Author

Kyle Rutledge, DO, PhD, is in his second year of the child and adolescent psychiatry fellowship at Central Michigan University College of Medicine. Before medical school, he completed his PhD in human development at the University of California, Davis. His research interests broadly span child development, though most recently have been focused on epigenetics, trauma, and resilience.

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Correspondence to Kyle Rutledge, DO, PhD; e-mail: rutle2k@cmich.edu

This article was edited by Justin Schreiber, DO, MPH.
Hurricane Harvey: A Psychiatry Resident’s Perspective

Anastasia Klott, MD

Over a 4-day period in late August 2017, a total of one trillion gallons of water fell across Harris County, Texas.1 For some perspective, this is the equivalent of covering the entire county in 33 inches of water.2 Hurricane Harvey was the second most costly hurricane in US history, behind Hurricane Katrina in 2005.3 When Hurricane Harvey made landfall in late August 2017, I was in my third year of general psychiatry residency, living in the heart of downtown Houston, Texas.

As a South Texas native, I have experienced my fair share of hurricane watches and warnings. My childhood memories include weekends of hunkering down and riding out Hurricanes Rita and Bret. We were spared of the catastrophe that was Hurricane Katrina, though we were always aware that our time would eventually come. Life as a medical student in Houston had been peppered with a few flash floods, many of which would leave city streets completely submerged and undrivable. As a third-year general psychiatry resident, a patient in my outpatient clinic was the first to warn me of the hurricane brewing in the Gulf of Mexico. I was not a particularly avid viewer of the local news at the time, but his concern was enough for me to check the internet and see what all the fuss was about. After work, I drove to the nearest grocery store to stock up on the essentials, a vital routine that was ingrained in me as a child. In my outpatient clinic the next day, more than half of my patients did not show to their scheduled appointments, as they were all boarding up and preparing for Harvey. When I called to check in on them, they firmly advised me to do the same. I arrived at home that evening, still somewhat uncertain of just how serious the threat could be for us living in Houston. Worried about the fate of my family down in South Texas, sleep was next to impossible that night. Thankfully, they were spared, though many of our beloved beach day trip destinations were not.

In Houston, the rain came down and did not cease for 4 long days. Harvey decided to hover in place directly over us, an uninvited guest clearly overstaying his welcome. In our downtown apartment, my husband and I watched the chaos and turmoil across the greater Houston area on the news. As we watched the tragedy unfold in our city, we were simultaneously checking on the raging waters in the overflowing Buffalo Bayou directly behind our apartment. We packed our suitcases with our most cherished personal items and prepared to evacuate our first-floor apartment if worse came to worse.

Some of my residency classmates lost electricity and internet service, rendering them essentially useless on call at home. I volunteered to swap one of my classmate’s in-home call for our outpatient clinic, thinking to myself “how bad can it be?” I quickly learned how wrong I had been in that assumption. In the chaos of evacuation, most people do not have the time and do not think to pack their medication. Taking call during that time gave me new and immediate experience trouble shooting minor medication adjustments in the moment via telephone for patients I had never met before. The widespread closure of retail pharmacies across the area made calling in prescriptions nearly impossible. While on call under these new circumstances I was also worried about my best friend and fellow resident, as well as her family. Her elderly grandparents were forced to evacuate their flooded home and had been featured on the local news coverage.

The local news depicted the displaced people of Houston, forced to evacuate to the downtown convention center, just a couple blocks away from my apartment. As I was sitting in my dry, air-conditioned apartment, I felt an immediate obligation to help those who needed it most. I arrived at the convention center to find thousands of cots on the ground, and the medical area was completely overflowed with people needing various
kinds of assistance. Initially, there was a rudimentary pharmacy set up with a limited supply of medication on folding tables, and an even more limited supply of psychotropic medication. Later, many large, well-known retail pharmacies parked mobile pharmacies inside the convention center and filled a few days’ worth of medication we wrote on makeshift prescriptions. Many of the evacuees had to wade through water to get to higher ground and help, and many of them did not have time to pack an overnight bag, let alone their medication. It was a whirlwind of a few days witnessing the juxtaposition of extreme disaster and sense of community simultaneously inside the convention center. Just over 2 years prior, my medical school classmates and I donned our graduation caps and gowns for our commencement ceremony in that same convention center.

Eventually, the flood waters receded enough to be able to make it into my outpatient clinic, giving me a sense of normalcy. It was hard to return to this routine without a sting of guilt, knowing there were so many families who would wait months to get back to some sort of normalcy. The sense of community I witnessed at the convention center trickled into every interaction with my patients afterward. We had all shared in this horrific, catastrophic experience together. Each visit with a patient after Harvey always began with “are you and your family okay?” My patients would inquire as to how I had fared through Harvey, and if my home was still intact. I struggled with answering these questions, as I had previously been taught to limit any self-disclosure to patients. I quickly realized that these inquiries from my patients were an indication of their authentic, genuine concern about me as another human being. It had less to do with boundary violation, and more to do with sincere interest after a shared traumatic experience. When both patient and therapist have lived through a traumatic experience, the humility of the therapist’s self-disclosure can outweigh the standard neutrality of the therapist. Greater leaps in the therapeutic process can be a by-product of therapist self-disclosure in the wake of a shared trauma. Such self-disclosure requires sensitivity to a patient’s needs and emotional state so that it is affirming of his or her experience, rather than overwhelming or burdensome.

I have found much reassurance in reading Rao and Mehra’s account of shared trauma and self-disclosure in the aftermath of Hurricane Sandy. In the aftermath of Hurricane Sandy, the author provides a first-hand account of the interwoven professional and personal experiences that came out of such a devastating disaster. Along with thousands of people in the Northeast United States, the author watched the flood waters wash away 35 years of memories “before my very eyes.” Faced with many personal questions by a patient regarding the storm’s impact, the therapist wrestled with disclosing personal information, and ultimately did so. This led to a turning point in the therapeutic relationship where a previously resistant patient began to open up, initially with feelings related to the storm, and subsequently with more personal struggles. One can assume that self-disclosure by the therapist created a level playing field in the therapeutic space where there was not one before.

I was pleasantly surprised by some of my patients who seemed to thrive in the face of tragedy and chaos. One of my patients had been a part of the home boater rescue brigade, depicted on news coverage evacuating families in flooded neighborhoods. Another patient, whose home had been flooded, managed to take the whole experience in stride. He was thankful it was merely his material possessions that had been lost, even if that meant replacing a nearly brand-new washing machine and dryer. I found myself identifying most closely to my patients who had been isolated to their home, with the threat of flood waters inching their way to their front door. I started to recognize my own acute stress response, particularly in nightmares where I would encounter a road with flood waters quickly rising, unsure of where to go. For a period after Harvey, any forecast of precipitation had me uneasy and questioning just how much more water the city could possibly handle.

Each patient encounter in the aftermath of Hurricane Harvey reiterated the concept of shared trauma. An important piece of recovery after a disaster is restoring normalcy, which typically means a return to usual daily activities like work. This shared trauma differed from the usual types of trauma we most commonly treat
because the patient and therapist are both victims. The perpetrator, in this case, is mother nature. Mother nature is not easily identifiable and can’t be brought to justice.³ We could not demand retribution against Hurricane Harvey and mother nature; the closest we could get was shaking our fist angrily at the sky. The therapeutic process in the months following Hurricane Harvey made for a unique, distinctive experience in my training as an outpatient psychiatrist. Together, through our shared experience, my patients and I were able to recognize, process, and adjust to life after Hurricane Harvey.

As COVID-19 has quickly uprooted our personal and professional lives to virtual meetings and encounters, this topic of self-disclosure has been at the forefront of my mind. In the rapid adjustment to working from home and telehealth, I have found myself comparing this societal shift to my life in the aftermath of Hurricane Harvey. Just as I did back then, I have witnessed the power therapeutic self-disclosure can have on the doctor-patient relationship. I have validated many of my patients fears and joined with them in those feelings, making myself vulnerable while equalizing the relationship. While I initially believed our relationships might suffer with this shift to virtual treatment, I have observed the therapeutic space flourish with our newfound shared experience. We are all continuing to adjust to our new home-bound, socially isolated lives, unsure of when, or if, they will return to the way things used to be.

**Take Home Summary**

Mental health providers are not immune to traumatic experiences. When a natural disaster, act of terrorism, or global pandemic occurs, this shared traumatic reality can weave its way into a therapeutic relationship. When appropriate, self-disclosure can be used as a tool for clinical benefit.

**References**


**About the Author**

**Anastasia Klott, MD,** recently completed Child and Adolescent Psychiatry Fellowship at the University of Colorado School of Medicine, where she has now joined as faculty. Professional interests include consultation-liaison psychiatry, the impact of social media use on mental health, and medical education.

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Correspondence to Anastasia Klott, MD; e-mail: anastasia.klott@cuanschutz.edu

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Knowledge of Child Refugee Experiences Through Non-Fiction Texts

Mary C. Chavarria, MD

I am a native of Los Angeles, California, and daughter to a Mexican immigrant. As a fourth year medical student interested in child psychiatry and trauma, with separation of immigrant and refugee families rampant in the news and JAACAP’s development of a literature and resource collection, I became compelled to know more. I soon learned that refugees are the fastest growing population in the world, their needs are largely unmet, and 50% of refugees are aged 18 or younger. We encounter them clinically and personally, and we are often under-prepared to meet their needs. I found valuable insights in 3 non-fiction texts:

The Children of Château de la Hille by Sebastian Steiger (referred to as Château throughout the remainder of this article): An account written by a teacher at a castle that hid away over 100 children at the foot of the Pyrenees in occupied France during World War II; it is written both from his perspective and using written accounts of the children themselves, remarkably, most of whom escaped alive. These texts share several key elements. Essential to these children’s experiences were family, identity, home, and loss thereof. The children additionally face developmentally inappropriate challenges and expectations with accelerated, forced adulthood roles. These texts detail suffering and how different individuals experience it. Some cope adaptively, while others maladaptively, or not at all. The stories communicated in each book help providers understand the significant psychiatric implications of what child refugees have endured.

They Poured Fire on Us from the Sky: The True Story of Three Lost Boys from Sudan by Benjamin Ajak, Benson Deng, Alephonsion Deng, Judy A. Bernstein (referred to as Fire throughout the remainder of this article): A collection of the stories of 3 young Sudanese boys driven from their homes during the civil war between 1987 and 1989, who like tens of thousands, became known as the Lost Boys. They streamed out over Sudan on foot, fleeing first to Ethiopia before being driven back into Sudan towards Kenya before finding their new lives in America.

City of Thorns: Nine Lives in the World’s Largest Refugee Camp by Ben Rawlence (referred to as City of Thorns throughout the remainder of this article): Reportage by a journalist who visits Dabaab, the world’s largest refugee camp situated deep within the inhospitable desert of northern Kenya—it is variably a humanitarian crisis to charity workers, a ‘nursery for terrorists’ to the Kenyan government, a dangerous no-go area to the western media, and last resort to its half a million residents, many of whom are children.

When it comes to a child’s initial sense of self, family is vital. In Château, while the children sought nominal medical care, they benefited from something greater. The author (occasionally sentimentalizing childhood) writes, “They all needed to feel they belonged here as members of our ‘family,’ so a bit of ointment gently applied to a finger could sometimes do the trick” (p. 115). By adopting a surrogate parent, the children identified someone to rely on, model authority, generate structure, and provide comfort. Similarly, in Fire, Alepho reports better times in structure and community: “once I was with a group of boys, many of them, in a settled place, I saw a change in myself. I tried to fit in. We would go out and play soccer in a group, shouting, ‘We are the best team! We are the strongest team!’” (p. 129). Another boy shares: “Family had become so precious to me. Without it I was like a tree alone in a desert” (p. 111). “my heart soared at the possibility of seeing my oldest brother, of being with an elder from my own
family, someone who cared about us and would know what to do” (p. 133). The surrogate “family” serves as a stabilizing force for the uprooted child.

Being uprooted from home poses a physical and personal existential threat. Separation from one’s family removes societal protection and increases danger. Deng unflinchingly recalls, “Back in Juol, anyone who knew my father’s name would treat me with respect. On my own, people insulted me, kicked my hand and whipped me. I was nobody” (p. 177-178). Following mistreatment, Ajak shares how “I didn’t know why he did that to me. Maybe because I didn’t have adult family, because I was just a kid” (p. 205).

With loss of family, these children describe loss of identity, respect, and safety. The young are pushed into adult circumstances by adult conflict. Children are militarized, commodified, and seen as a renewable, disposable resource: “They wanted more boys for their army. Soon we would be on the front lines, where they didn’t care whether you lived or died. They said, ‘Thousands die and a hundred are born a day. Who cares about your life at your age?’ Our lives seemed of no consequence to them” (p. 223).

As Rawlence discusses for some of the Lost Boys and other inhabitants of Dabaab, there is an element of listlessness in waiting. While there are some who maintain and nourish dreams of escape and exhibit phenomenal resilience, there are others for whom the thoughts of fleeing are inconceivable. Rawlence writes, “For a mind shaped by the confusion of war, the ability to imagine that life might be different or better elsewhere is an uncommon leap” (p. 19). Rawlence describes “Muna [who] was perhaps the ultimate child of her generation. Raised in the limbo of the camp, the true daughter of Dadaab, Muna had relinquished responsibility for herself entirely to the testing mercy of events. It had become a way of life” (p. 210-212). After having been powerless for so long, the individual no longer attempts to take charge or change anything. In this way, child refugees may be difficult to engage, following such decimation, but it remains vital to try.

The authors identify an additional barrier—fear of the traumatized person. Steiger, haunted by the memory of Rosa, harbors feelings of guilt for how he feared this traumatized child, questioning how his feelings contributed to avoidance versus intervention.

Rosa Goldmark, a child clearly in distress. Her behavior was very strange. Nevertheless, I might have taken the time to be with her. She did everything possible to avoid people and wandered around the Château as if she were living in another world. Was I too young, or was I too preoccupied with my own concerns to help Rosa? I don’t know. Perhaps I was really afraid to approach her and even to try to understand her. The idea that she might cling to me like a drowning person clings to a buoy frightened me. If I had had the least suspicion of how much she was suffering, perhaps I could have helped her (p. 93-94).

Difficult to engage and overlooked by caregivers, Rosa deteriorated. While a number of children sought connection and care in the infirmary for concerns big, small, or imagined, Rosa “had never come to see me in the infirmary… Only a very few – perhaps Rosa was the only one – never came at all” (194). Thus, she further reinforced her otherness, discouraging intervention. While the majority of children housed with her went on to have inspiring stories of survival and escape, Rosa charted a more dismal path, withering away and dying, psychotic, in a psychiatric hospital at age 17. While Rosa’s story, complicated by psychopathology, does not apply to all who have suffered trauma, her tale begs the question of what can be done when one is so entrenched in their isolation. Steiger wondered what he could have done differently and even how much of a role he could have played. The consequences of one fearing and avoiding those traumatized are grave. We must recognize our unconscious bias, counter-transference, discomfort, and fears in order to be most present and provide the best care to this important population.

These perspectives highlight the diversity of refugee experiences. While no one voice speaks for all, by listening to many, certain commonalities emerge and the differences are complex. When observing the development of psychopathology (such as Rosa’s) and other
posttraumatic psychotic experiences, it may be difficult to disentangle independent psychiatric illness from trauma reactions. The outcome regardless is a complicated interplay between predisposition and experience. As refugees, especially children, they share trauma and developmentally inappropriate challenges. The trauma may become a lasting legacy that reverberates through generations. However, with the support and care of the Château, the vast majority of the children grew to lead happy, successful lives. Despite the horrors they endured as detailed in Fire, these 3 boys developed into successful authors and advocates in the setting of re-establishment with community and mentorship. In City of Thorns, Tawane, a once traumatized youth, connected with a volunteer group in the camp, was elected leader, and went on to communicate and advocate with the United Nations. With awareness and intervention, opportunity exists for maturation, reflection, and growth.

Take Home Summary

Refugees are the fastest growing population in the world, their needs are largely unmet, and half are 18 or younger. They experience loss of family, identity, home, and safety. Without appropriate attention, they face a lasting legacy of trauma.

References


About the Author

Mary C. Chavarria, MD, graduated Washington University School of Medicine in St. Louis in 2019 and is a resident at the UCLA Greater Los Angeles Veterans Administration Psychiatry program.

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Correspondence to Mary C. Chavarria, MD; e-mail: mchavarria@mednet.ucla.edu

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Developing Successful Mental Illness Prevention Efforts on University Campuses: A Local Look Based on the CARES Program at Stanford University

Vishnu Shankar, BS, and Ronald C. Albuquer, MD

Abstract
There is a well-evidenced trend that the prevalence of youth depression and anxiety is increasing, especially on college campuses. Due to finite university resources directed to student mental health and well-being, mental health prevention efforts are strongly needed to help prevent the onset of mental illness in high risk students and to manage the large numbers of students requesting services. We provide a specific example of CARES, a 3-session program that teaches graduate students practices for sustaining mental resilience and well-being along with relevant local campus resources. Preliminary results from pilot testing our program in 3 graduate departments at Stanford University show an 18% and 7% average increase in resilience and flourishing related outcomes. Our results suggest that even short-term interventions can better support graduate student mental well-being. We hope that some of the insights learned from building this program can guide the implementation of mental illness prevention efforts at other college campuses.

Background
Across college campuses, there is a need for effective mental health prevention efforts. There are barriers to implement preventive services, including that it is difficult for universities to identify the students who need preventive services or treatment for existing mental illnesses. Even if you can identify those who need services, college mental health centers nationally are struggling to meet the increased demand for clinical services. Therefore, effective mental illness prevention efforts ought to reach high-risk students to help prevent onset of illness, while reducing the burden on clinical services.

Introduction
We know the first emergence of mental disorders occurs most commonly between the ages of 15 and 24. Studies in academic journals and reports in the press have raised concerns regarding an increase in prevalence of depression and anxiety in university students. Among graduate students, it is estimated that the risk for experiencing depression and anxiety is significantly higher compared to the general US population. In recognition of this trend, the question arises, “What can be done to address the mental health needs graduate students, with the limited resources institutions can devote to mental health care?” The aim of this article is to provide an “on the ground” view of the practical challenges and approaches taken to enhance prevention efforts and early detection of mental illness based on an intervention that was conducted at Stanford University. This article will discuss the intervention, the evaluation of that intervention, and future directions to address university student mental health.
illness for graduate students are not very well characterized, but it is known that the lack of a clear work-life balance and the relationship between principal investigator and trainee can have a disproportionate adverse effect on student mental well-being.\(^4,\(^7\)

CARES, a program piloted at Stanford University, provides an example of the planning, development, and implementation of a specific mental health prevention program. CARES directly brings mental health well-being services to graduate communities. The idea of CARES was formulated based on discussions with over 50 students, clinicians, faculty, and health professionals on Stanford’s campus, along with an extensive review of published literature in PubMed and Google Scholar for “risk factors for mental illness among college students”, “mental well-being among college students”, and “mental health prevention programs for college students”. Our discussions and research led us to the following observations:

- **Presentation of mental illness symptoms among students is extraordinarily diverse:** Students reporting symptoms of mental illness ranged from cases of dealing with childhood trauma to coping with a relationship breakup. Within this diverse range of cases, students with subthreshold psychiatric symptoms do not all require clinical mental health services.

- **Barriers for help-seeking need to be lowered:** Due to factors such as stigma and lack of knowledge regarding appropriate resources, many students do not seek early help or care for mental illness symptoms, thereby worsening symptoms. To lower the barriers for help seeking, the program was directly introduced into student communities.

- **There is a need to better support graduate students:** Graduate students are 6 times more likely to experience depression and anxiety compared to the general population, due to factors such as asymmetric work-life balance, difficulty in establishing long-term goals, and relationship with their principal investigator.\(^4\)

- **The on-campus programs are few:** Due to the sparse mental illness prevention programs to help the graduate student community at Stanford and other universities,\(^4\) there was a need to develop better support systems for graduate students mental well-being.

Our hypothesis was that we could educate students on personal skills to help cultivate long-term mental well-being and help identify the resources that are appropriate for student needs by teaching skills to students directly in smaller group settings. We also hypothesized that teaching this program in small group settings would create a more comfortable and effective learning experience, since students could learn the material with their social support networks.

**Method**

The first iteration of CARES was offered to students in 3 graduate departments (Mathematics, Sociology, Graduate School of Education) and a community center at Stanford University. Graduate students in these departments’ programs expressed initial interest to participate in CARES. The program consisted of 3 to 4 interactive sessions with small groups of graduate students consisting of 10 to 12 students. A brief summary of each session has been included below.

**Session 1: Resilience and Mindfulness:** There have been associations between gratitude\(^11\) and mindfulness\(^12\) on affective measures of well-being. In this session, students were introduced to exercises for gratitude, defining personal resilience, calming the nervous system, and guided mindfulness practice.

**Session 2: Self-Compassion/Taming the Inner Critic:** Self-compassion is the practice of directing compassion inward,\(^13,\(^14\) where compassion is defined as “sensitivity to the experience of suffering, coupled with a deep desire to alleviate that suffering.”\(^14\) Students were taught techniques for cultivating self-compassion, such as affectionate breathing or writing a letter to oneself from the perspective of a kind friend.\(^13,\(^14\)
Session 3: Values/Mission and Resources: In other cohorts, it has been shown\(^{15}\) that purpose and finding meaning from life experiences helps build resilience and predicts better recovery from difficult emotional stimuli. Students were taught to consider what values are most important for their own goals. Further, students were guided to construct a meaningful mission statement that summarizes one’s aims, values, and core purpose. In this session, students were also educated on the available campus resources, including courses and programs on student wellness, counseling and psychological services, student organizations, health promotion services, etc.

To evaluate the outcomes of the workshop, 2 pre- and post-test surveys were administered based on the Brief Resilience\(^{16}\) and Short Flourishing Scale.\(^{17}\) The Brief Resilience Scale, which has 6 items, provides a score of how well responders perceive their ability to bounce back from adversity. The Short Flourishing Scale, which has 8 items, measures psychological well-being, by evaluating the responder’s attitudes towards their own relationships, self-esteem, purpose, and optimism. Both measures provide a single score, based on aggregating the answers to each item in the survey. These 2 surveys were selected, since it best reflected the CARES program topics on personal well-being and resilience. Additionally, as both measurements have been validated for their reliability in diverse adolescent populations,\(^{18,19}\) it was likely that these scales can appropriately capture how the CARES program affected individual student resilience and psychological well-being.

Results

Overall, we surveyed 24 participants with both scales before the first session and 16 after the last session of the program. We found 89% of participants highly recommended the program with 11% of participants possibly recommending the program. In evaluating the pre vs post-test survey results, we note an overall 18% increase from pre vs post-test on the Brief Resilience Scale and an overall 7% increase in mean scores from pre vs post test on Short Flourishing Scale. The % increase in mean scores was determined by calculating the percentage change in average participant scores before and after the program for each scale. A 2-sided Welch’s t-test suggests that the increase in resilience and flourishing outcomes are both statistically significant (\(p < 0.01\)). Table 1 summarizes these results.

<table>
<thead>
<tr>
<th>Measurement Scale</th>
<th>Pre (n)</th>
<th>Post (n)</th>
<th>Average Pre Scores</th>
<th>Average Post Scores</th>
<th>% Increase in Mean Scores</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Resilience Scale [1.00, 5.00]</td>
<td>24</td>
<td>16</td>
<td>3.05</td>
<td>3.60</td>
<td>18</td>
<td>(p &lt; 0.01)</td>
</tr>
<tr>
<td>Short Flourishing Scale [8.00, 56.00]</td>
<td>24</td>
<td>16</td>
<td>43.58</td>
<td>46.56</td>
<td>7</td>
<td>(p &lt; 0.01)</td>
</tr>
</tbody>
</table>

Note: For the Brief Resilience Scale, a score of 3.00-4.30 is considered normal resilience.
Discussion
The results from this survey suggest that a short-term program can have a positive effect in cultivating skills for self-resilience and improving overall well-being, but the work is preliminary and has several limitations. It is not clear if the effects found in this small sample size effectively generalize to other student populations due to some students only attending 1 or 2 out of 3 sessions. It was not logistically possible to carry out 6-month follow-up, so it is unclear if the positive effects from CARES pertaining to resilience and flourishing-based outcomes sustain beyond the immediate intervention. To robustly evaluate the effect of this program would require testing CARES with more students, evaluating program outcomes in diverse cohorts, and tracking students long-term. Since piloting CARES, we are already taking steps to follow-up by testing the program in different departments at Stanford and in different universities, including the University of Madrid.

Conclusion
To date, there is limited data regarding the efficacy of university-based mental health prevention programs. With rising rates of mental illness and suicides among college students, it is clear that there is a much-needed shift in the way that mental illness and health are conceptualized on university campuses. Part of this shift may come from making student well-being a central priority of every university by integrating student life with programs involved in promoting student mental health and wellbeing. Based on our CARES program, which involved collaboratively working with students, psychiatrists, and mental health professionals, we envision that considerations for student mental well-being ought to be incorporated in the graduate school curriculums. This endeavor would involve working closely with mental health professionals and child and adolescent psychiatrists to help students develop healthy mechanisms to cope with the large periods of uncertainty and stress in graduate school. When adolescent and child psychiatrists work to support student mental well-being with graduate programs, it can also help ensure that students can at least develop the mental health literacy needed to recognize symptoms of mental illness in self and peers, thereby ideally lowering the barrier for help-seeking.

As our efforts have shown, part of this effort will involve navigating difficult practical challenges, such as scheduling programs around students’ busy schedule, evaluating program outcomes when no structured framework exists at the college level, and working within the bounds of university governance and cost constraints. We believe that efforts like CARES are a small step in this direction.

Take Home Summary
With rising rates of mental illness among college students, we developed and tested the CARES program at Stanford University, which teaches students skills for building emotional resilience. Our initial results suggest that CARES may help in lowering student risk for mental illness.

References


About the Authors

Vishnu Shankar, MS, is a master’s student at Stanford University, California, studying computer science. Based on his strong interests in promoting student mental wellbeing, he proposed and founded the CARES program (https://sites.google.com/view/caresforwellbeing/home) involving mindfulness practices, education on availability of campus resources, and student storytelling.

Ronald C. Albucher, MD, is a Clinical Associate Professor of Psychiatry and Behavioral Sciences at Stanford University, California. From 2008–2017, he was the Director of Counseling and Psychological Services at Vaden Health Center.

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Correspondence to Vishnu Shankar, MS; e-mail: vishnus1@stanford.edu.

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Reaching Across the Table: Conflict Resolution Skills for the Child Psychiatrist

Lisa Hutchison, MD, Elizabeth Menefee, MD, Neha Sharma, MD, Martine Solages, MD

Few child and adolescent psychiatry fellowship programs offer substantive leadership development training, despite the fact that child psychiatrists frequently step into leadership roles soon after training.1,2 Becoming an effective and collaborative leader is a multidimensional process and the fine-tuning of leadership skills such as conflict resolution is one important step. Conflict resolution skills are essential for a child psychiatrist working with parents, teachers, and community leaders as they navigate interdisciplinary settings, balance competing interests, and advocate for their patients. This article will provide readers with a basic understanding of different conflict resolution approaches and how to flexibly apply them to different situations.

Background

While conflict tends to be seen as antagonistic and destructive, the presence of differing viewpoints can be beneficial in collaborative settings.3 Differences in perspective and judgment, when approached with a flexible mindset, can introduce new ideas, produce novel solutions, and enhance relationships. Leaders can more effectively engage in conflict resolution when they first understand their own personality and leadership style, and how their style may be appropriate or potentially inflammatory for the situation. Biases, triggers, and personality all come into play when facing conflict.

There is no single technique for resolving conflict because every situation is unique. Choosing how best to resolve a particular conflict is aided by a basic understanding of the different conflict resolution modalities. The idea of breaking up conflict resolution into different modes was first proposed by management theorists Robert Blake and Jane Mouton in the 1960s. They proposed that leadership styles and skills could be described through dimensional models.4 Blake and Mouton broke down the approach to conflict resolution into 2 dimensions: cooperation to satisfy another's needs and assertiveness to satisfy one's own needs. Conflict “modes” were described based on their level of each dimension.

The “competing mode” is one of high assertiveness and low cooperation, in which one seeks to use authority to satisfy one's own needs without regard for the needs of the other party. While this approach may seem callous at first, it has its uses. For example, a psychiatrist may need to use the competing mode when hospitalizing a suicidal patient against his will. The “accommodating mode” is characterized by high cooperation and low assertiveness. In the accommodating mode, one prioritizes the other party's needs over one's own needs. This approach is most appropriate when the stakes are low and relationship building is important, such as when agreeing to work during a holiday so that a colleague can spend time with her family. The combination of low assertiveness and low cooperation was described as the “avoiding mode” in which one ignores the conflict and does nothing to resolve it. This is a common approach to conflict when stakes are low and the outcome is less important. However, the avoiding mode can lead to resentment and dissatisfaction when used too frequently. This can happen, for example, when a staff psychiatrist fails to tell his director that he is feeling overworked, thereby avoiding conflict but increasing burnout.

The “compromising mode” falls in the middle on both dimensions. When the compromising mode is employed, the goal is to reach a solution that is at least partially satisfactory to all parties, but completely satisfactory to none. An example of this would be the situation in which a parent agrees to allow screen time but only after...
homework is completed. In contrast, the “collaborating mode,” with high assertiveness and high cooperation, seeks to find an integrative solution which is satisfying to all. This approach requires a balance between nonthreatening confrontation (eg, “I hear what you’re saying, but I disagree and here’s why...”) and active listening, ie, listening while providing feedback and validation. It depends on the willingness and ability of all parties to engage in the collaborative process. While collaboration is the ideal, it is not always feasible, as when safety is a concern, and can be time consuming.

Selecting the Conflict Resolution Approach
Conflict can be resolved by first evaluating the situation then selecting a systematic approach. This can be carried out via the following steps:

1. Self-monitor. Assess your own immediate reaction. Reflect on your own values, biases, and past experiences and how these factors may impact the conflict resolution process. Furthermore, consider your own leadership style and which approach best integrates your strengths.

2. Establish goals. Clearly identify what you hope to achieve and what compromises you are willing to make.

3. Determine which approach is most appropriate given your goals and the circumstances.

4. Consider the ideal setting for the discussion, particularly in regard to privacy, neutrality, timing, and layout. For example, addressing conflict with a family in a waiting room may not be ideal and taking the time to move to a private space can be valuable.

5. Employ active listening skills. Active listening includes inviting the other person to express his or her concerns, clarifying and restating the other’s perspective, seeking confirmation that the information has been heard correctly, reflecting feelings, and validating concerns. Demonstrating an intention to listen lowers the defenses of someone who is expecting to have his or her needs dismissed.

6. Assert your own needs clearly and with flexibility. The other party cannot accommodate unless they understand both perspectives.

7. Build an agreement that is applicable to the specific situation. The solutions may not be perfect or satisfy all parties, but should be reasonable, feasible, and future-oriented.

Hypothetical Case 1
Dr. Smith evaluates a 12-year-old boy with autism and aggression in the emergency department and determines that the child would benefit from an inpatient hospitalization because his mother is overwhelmed and is unable to keep the child safe. The mother agrees with this plan, but tells Dr. Smith the boy's father, who shares legal custody and therefore all treatment decisions, is against admission and is on his way to the emergency department. The father arrives angry and shouting. He disagrees with admitting his son to an “institution” and demands immediate discharge. He is unable to take his son home due to his work schedule.

Approach to Case 1: First, Dr. Smith will need to self-monitor as verbal aggression can trigger strong emotional and physiological responses. Dr. Smith’s primary goal is to ensure a safe disposition for the child. While there is no “right” conflict mode for approaching a particular situation, there can be a wrong one. Here, the conflict cannot be avoided and accommodation of any one party is likely to worsen the problem. The ideal approach would be a collaborative one, given the shared custody, but this first requires de-escalation of the father’s agitation. A competing approach—exerting Dr. Smith’s authority as the evaluating psychiatrist—may be necessary, but could have detrimental effects on the father’s future interactions with mental health care clinicians and the likelihood of successful co-parenting. Given the father’s agitation, a safe location should be identified for the discussion. Dr. Smith should take a listening stance and be open to understanding the father’s concerns about “institutions.” Once the father’s concerns are validated, the needs of the child should be reiterated clearly. Collaboration requires flexibility:
for example, outpatient treatment may be reconsidered if the patient is not imminently at risk. The parents should both be approached with calm and respect, and both views should be validated. The goal is to build an agreement that considers the perspectives of everyone involved, but it must also be feasible.

In this case, Dr. Smith sits down with the patient’s father in a private consultation room while the mother stays with the patient. He listens to and validates the father’s concerns, calmly provides psychoeducation, and encourages the father to ask questions without judgment. After reviewing all disposition options, the father agrees that a brief inpatient hospitalization may be helpful and provides his consent.

Hypothetical Case 2
Dr. Patel has been working at her current faculty position at an academic institution for the past 5 years. She enjoys working in the outpatient clinic, but charting burden has increased over the past few years and funding for support staff has decreased. During her annual performance meeting, her division chief tells her that there is pressure on the psychiatry department to increase revenue. As result, clinic faculty will be expected to see 10% more patients, which means 5 additional patient appointments per week.

Approach to Case 2: Before engaging in any approach, Dr. Patel should reflect on the nature of the conflict. Affective conflict (conflict based on emotions and personal differences) tends to be destructive and unproductive. Cognitive conflict, on the other hand, is task-oriented and arises from differences in perspective or judgment and can be productive. In this case, is Dr. Patel’s frustration due to the burden of extra appointments or to feeling undervalued? In selecting her conflict mode, Dr. Patel should weigh the relative importance of the issue versus her relationship with the division chief and consider the power imbalance. A number of conflict modes could be appropriate in this case: compromising, collaborating, or accommodating. The competing mode would be inappropriate due to the power differential which favors the division chief. The avoiding mode would be a short-term solution and could lead to resentment. By assuming a listening stance, Dr. Patel can better understand why this change is necessary for the department. She should assert her own needs clearly so that her division chief is aware of the challenges. While she may not change the department’s expectations, the discussion may shed light on opportunities to decrease other demands on Dr. Patel’s time or to provide additional support and mentorship.

After brief reflection, Dr. Patel concludes that her frustration is driven not by the number of patients, but rather by feeling unheard and undervalued. She chooses to take an accommodating approach and agrees to the increased productivity expectations, but states her own needs for increased support staff and administrative time. The division chief agrees to continue working on these issues and offers to identify a senior faculty member who can serve as a formal mentor.

Conclusion
Conflict generally has a negative connotation, but it is a natural aspect of a team dynamic. Conflict can be beneficial when approached with a flexible mindset. Differing opinions and perspectives can be a starting point for growth and collaboration. Child psychiatrists are in a position to become leaders within institutions, communities, and organizations, and the development of leadership skills is essential. Conflict resolution is one skill that can promote an environment of teamwork and collaboration when used effectively.

Take Home Summary
Effective conflict resolution skills are essential for psychiatrists in their practice and when taking on leadership roles. While daunting at times, conflict can serve a role in problem solving and relationship building when approached in a systematic way.

References


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**About the Authors**

**Lisa Hutchison, MD,** is an assistant professor of psychiatry and behavioral sciences at Albert Einstein College of Medicine and Montefiore Medical Center in the Bronx, New York.

**Elizabeth Menefee, MD,** is an instructor of psychiatry at Northeastern Ohio Medical University and chief medical officer of the Child Guidance and Family Solutions in Akron, Ohio.

**Neha Sharma, MD,** is an assistant professor of psychiatry at Tufts University School of Medicine and child and adolescent psychiatry fellowship director at Tufts Medical Center, Boston, Massachusetts.

**Martine Solages, MD,** works in private practice in Bethesda, Maryland, and with the Food and Drug Administration.

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Correspondence to Lisa Hutchison, MD; e-mail: lhutchis@montefiore.org

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Registration Opens in Mid-August
Effective Interdisciplinary Medicine: Psychiatric Care in Children and Adolescents With Type 1 Diabetes

Amy Lynn Meadows, MD, MHS, Sonya Jayaratna, MD, Victoria Vorholt, MA, Alba Morales Pozzo, MD

Diabetes mellitus type 1 (T1D) is one of the most common chronic illnesses in pediatrics. Child and adolescent psychiatrists (CAPs) may encounter pediatric patients with T1D whose emotional disruption increases the risk for poor glycemic control or diabetes complications. CAPs can assist pediatric providers and patients with T1D by providing collaborative care, including patient and family education, monitoring for common emotional and behavioral concerns, and treatment. We will briefly review common presentations of anxiety, depression, disordered eating, attention-deficit/hyperactivity disorder (ADHD) and family conflict in T1D. Mental health is an essential component of an integrated approach to pediatric diabetes care.

T1D is an autoimmune condition which commonly appears first in youth, which was previously known as juvenile or insulin-dependent diabetes to distinguish it from type 2, or insulin-resistant diabetes. T1D affects nearly 1.25 million people in the United States, with 18,000 new diagnoses per year in those under age 20. Youth diagnosed with T1D must perform a complex set of steps in order to achieve optimal glycemic control. After diagnosis, a child and parent must start treatment with a pediatric endocrinologist, learn to monitor and manage blood sugar, understand meal-based carbohydrate calculations, administer insulin, and react to new signs and symptoms. Because of the challenges of adjustment to living with a chronic illness and the unique stresses of diabetic self-management, CAPs can play a crucial collaborative role in providing education, screening, and treatment of pediatric patients with T1D.

Current American Diabetes Association and American Academy of Pediatrics recommendations suggest screening all children with T1D annually for psychiatric and psychosocial factors that can influence metabolic control. While some patients may have mood lability or irritability in response to glucose highs or lows, they are also at higher risk for psychiatric disorders. Nearly 1 in 3 youth with T1D also have depression, while 1 in 5 have an anxiety disorder. As a child with T1D grows and gains autonomy over their diabetes management, the risk for emotional disruption increases as children transition into adolescence and young adulthood. Psychiatric symptoms in adolescents predict risk for hospitalization for diabetic ketoacidosis, a life-threatening complication. Children with diabetes face risks of both acute metabolic complications, such as diabetic ketoacidosis or hypoglycemia, as well as longer term risks of microvascular (retinopathy, neuropathy, nephropathy) or macrovascular complications. Depression, anxiety, disordered eating, ADHD and family conflict can all be associated with unique management challenges that can increase the risk of these poor metabolic and microvascular outcomes.

Anxiety and Depression

Anxiety and depression are associated with negative impacts on metabolic control and diabetes self-management. CAPs can help identify specific emotional challenges and formulate team-based responses to those difficulties. For instance, patients with needle phobia can struggle with the need for frequent glucose checks and insulin shot administration. While continuous glucose monitoring systems and insulin pumps may allay some anxieties, they still require frequent and active diabetic management, such as responding to alarms.

Additionally, increasing depressive symptoms is associated with poorer glycemic control. Adolescents with depression are less likely to accept parental assistance with diabetes care. Moreover, compared to the general population, youth with T1D are at an increased risk.
for suicidal ideation, suicide attempts, and suicide.\textsuperscript{11,12} Because youth with T1D have access to potentially lethal means such as insulin, safety planning may have to specifically address how to ensure means restriction while continuing diabetic management.

Diabetes-specific psychotherapy can be helpful for diabetes-related distress and depression or anxiety. For instance, group diabetes-specific coping skills training, which covers both education and adaptation to the illness, has been effective in youth, decreasing isolation and improving coping.\textsuperscript{13} Individual and group cognitive-behavioral therapy has been effective in adults with T1D, but those effects have not been consistently demonstrated in youth.\textsuperscript{14-16} Antidepressants, including selective serotonin reuptake inhibitors such as fluoxetine, remain the standard of care for major depressive disorder and anxiety disorders.\textsuperscript{17} Augmentation with atypical antipsychotics may have metabolic consequences, including increased risk of hyperglycemia, and require additional caution.\textsuperscript{18,19}

**Diabetes Distress**

Patients with T1D, especially adolescents and young adults, may also experience difficulties with adjustment, which is sometimes called diabetes distress, characterized by poor coping or denial about the illness.\textsuperscript{20} As a child understands more about their illness, they may struggle with telling teachers and friends, or have guilt or embarrassment about their diagnosis or being “different.” Diabetes distress may elicit an emotional response to specific daily diabetes self-management, such as fear of injections or anxiety about blood sugar. Cognitive distortions about diabetes have been associated with increased stress and worse glycemic control.\textsuperscript{21} Specific rating scales, such as the Diabetes Distress Scale, can help identify youth at risk.\textsuperscript{22}

**Eating Disorders**

Disordered eating, including under-dosing or skipping insulin, is much more common in adolescents, especially female adolescents, with T1D.\textsuperscript{23} Not only can under-dosing and associated hyperglycemia lead to unhealthy weight loss, but it can also increase the risk of complications of T1D.\textsuperscript{24} The Diabetes Eating Problem Scale can be used to screen for disordered eating and insulin misuse.\textsuperscript{25} Psychoeducation, providing information about the risks of under-dosing to adolescents with T1D as well as their parent and other care providers, can remediate some of the attitudes and behaviors associated with disordered eating and catch concerning behaviors early.\textsuperscript{26}

**Executive Functioning and ADHD**

Executive functioning encompasses planning and organizing abilities which may affect outcomes in T1D. To manage diabetes, one has to count carbs for each meal, calculate insulin, remember to bring insulin, figure out when and where they will be eating meals, and many more decisions that require planning and organization. Poor executive functioning has been repeatedly demonstrated to be associated with poor glycemic control, especially for adolescents.\textsuperscript{27-29} Those with a diagnosis of ADHD and T1D experience twice the risk of diabetic ketoacidosis.\textsuperscript{30} Although stimulant medication remains the treatment of choice for ADHD in those with T1D, the appetite-lowering effects of stimulants could put patients at risk of hypoglycemia.\textsuperscript{31} CAPs can provide guidance to children, parents, and the endocrine team about careful midday insulin dosing in those who experience appetite suppression. Behavioral treatment modalities such as working memory training have been used in adolescents with type 1 diabetes and show some benefits, especially when combined with other psychological treatments.\textsuperscript{32}

**Family Conflict**

Parents or caregivers take a primary role in managing T1D for many young children. School-age children are generally expected to understand and communicate symptoms of low blood sugar, carry diabetic supplies, and develop autonomy around eating, glucose checks, and exercise. Older children are expected to slowly and progressively take over the daily responsibilities of diabetes care.\textsuperscript{33} Older adolescents should be establishing and reinforcing self-care skills and learning to integrate these skills into their social and academic
lives. This will help to reinforce the relationship between diabetes control, prevention, and screening for its complications. Like other developmental milestones, individual and family variation contributes to the progression to independent diabetes self-management. Psychosocial and environmental factors, such as poverty and food insecurity, can play a significant role in family’s ability to navigate the additional challenges of T1D.

Given the crucial role of parental monitoring and gradual transition of autonomy, family conflict can be a unique risk factor for children and adolescents with diabetes. Assessing the child’s psychiatric symptoms and family functioning can provide meaningful information about the potential need for family intervention. Stressful family situations, including adverse childhood experiences, can contribute to emotional disruption and nonadherence to recommendations. Multisystemic Therapy and Family-Based Systems Therapy have demonstrated that intensive, family based treatments can improve glycemic control youth with T1D.

**Conclusion**

Recognizing that children, adolescents, and young adults with type 1 diabetes may be at risk of emotional disruption is an important opportunity for education, identification, and collaboration between healthcare providers. Because of their ability to identify vulnerability to common psychiatric symptoms and family dynamics in their interactions with patients with T1D, CAPs should be embedded within endocrinology clinics, providing early referral for concerns about patients and their family functioning and immediate response to positive screens. In addition to the benefit of their direct access to patients and their mental health, CAPs can help improve metabolic control and decrease the risk for complications by promoting and discussing the potential effect of these comorbidities with pediatricians and interdisciplinary health systems.

**Take Home Summary**

Children, adolescents, and young adults with type 1 diabetes commonly experience emotional disruption, conflict, and psychiatric illness that may affect their diabetes management. Collaborative relationships between child and adolescent psychiatrists and diabetes providers can facilitate education, referral, and treatment.

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### About the Authors

**Amy Lynn Meadows, MD, MHS**, is a triple-boarded child psychiatrist who works on the consultation-liaison service at Kentucky Children’s Hospital, Lexington, and is currently studying risk and resilience in children with type 1 diabetes.

**Sonya Jayaratna, MD**, is a PGY3 Triple Board Resident at University of Kentucky, Lexington.

**Victoria Vorholt, MA**, is an M3 Medical Student at University of Kentucky, Lexington.

**Alba Morales Pozzo, MD**, is a pediatric endocrinologist at the Barnstable Brown Pediatric Diabetes Center at University of Kentucky, Lexington.

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Correspondence to Amy Meadows, MD, MHS; e-mail: amy.lynn.meadows@uky.edu

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Bringing Psychiatry and Oncology Together Through Case-Based Learning

Zheala Qayyum MD, MMSc, Asher Marks MD, Gerrit van Schalkwyk, MD

Case-based learning is a well-established teaching method in medical education which promotes critical thinking and facilitates a real-world context that aligns with trainees’ clinical experiences. This method is particularly relevant in the field of psycho-oncology, which requires a holistic approach to patients, especially with children, adolescents, and young adults with unique developmental considerations. Individual providers are typically not experts in all areas of psycho-oncology, and therefore, effective practice requires a functioning multidisciplinary team where different perspectives and expertise can come together. This also allows for patient perspectives to be routinely solicited to ensure that treatment is coordinated and responsive to the patient needs.

In our general psychiatry program, nearly all residents in the program face the clinical task of supporting children, adolescents, and adults with oncologic diseases, as well as patients’ families and other members of the clinical team, during the internal medicine rotation. Therefore, we sought to create an educational experience to provide exposure to psycho-oncology, an introduction to multidisciplinary team care, and to highlight the importance of the patient perspective. Case-based learning was utilized to provide an authentic scenario with challenges that were reflective of medicine in practice.

Method

Our target population was second year general psychiatry residents. The educational experience included a one-time 2-hour case conference integrated into a standing case conference that was part of their yearlong didactics. The conference consisted of a case discussion with input from both a child and adolescent psychiatrist and a pediatric oncologist, a discussion with an adolescent cancer survivor and the parent of a deceased patient, and a question and answer session. Post graduate second year psychiatry residents who were part of a large urban residency program at a prominent academic institution participated in the case conference as part of their formal second year didactics. The conference aimed to provide a framework to explore and understand the perspectives of the patient, treatment team and trainee. Additionally, we aimed to bridge the gaps in the appreciation of roles and experiences of the different disciplines involved in the care of these unique patients and to model effective collaboration.

The deidentified case was based on a patient who was under the care of both the psychiatrist and the pediatric oncologist. The case was presented in sections, creating uncertainty around the final outcome in order to best model the realities of the clinical process. Each section was followed by questions posed to the trainees which highlighted key transdisciplinary constructs. Specific topics included:

- What constitutes a ‘terminal illness’?
- Approaching adolescent decision making and autonomy
- Mood symptoms in medically ill adolescents
- Navigating conflict between patient and parental preference
- Treatment refusal

Time was reserved for back-and-forth discussion both during the presentation and at the end of the session.

The presenters focused primarily on creating a safe environment within which challenging discussions could take place. They sought to demonstrate this with their own openness and modeling of vulnerability. For example, both the oncologist and the psychiatrist discussed their own experience of caring for the
patient within the duration of the session. They were able to share their own reflections about meeting with the patient and their family over the course of treatment and how the relationship evolved. Both physicians were open about the disappointments of relapse, addressing patient anxiety, and boundaries with the patient and their family. The discussion included an emphasis on collaboration and communication particularly in the areas of breaking bad news and managing the patient and family’s response in a developmentally appropriate manner. The child and adolescent psychiatrist worked closely with the oncologist to ensure that age appropriate ways in which the patient demonstrated their distress and anxiety was evaluated and separated from maladaptive responses. Conversations about end-of-life care, patient preferences, and directives were also discussed in the concluding part of the case. Modeling communication and collaboration while also acknowledging areas that could be improved provided a realistic view of what trainees could expect to encounter in practice. In addition, the values, beliefs and behaviors of the physicians were illustrated as they worked together. Development of positive and negative transference towards the patient, reflection on the physicians’ own status as a parent, and ideas about attending the funeral of the patient were openly discussed with the trainees.

**Results**

The formal resident feedback for the case conference was collected anonymously through the electronic feedback software standardly used by the program as it is required for the assessment of the educational curriculum and for quality improvement. The comments were also qualitatively reviewed. Participants rated the usefulness, content, and applicability of the case conference using a Likert Scale. This data was collected standardly as part of quality improvement. The residents found the experience to be interesting and engaging as well as emotionally charged. Identified areas of improvement were to provide more focus on the delivery of bad news and to incorporate a forum for residents to discuss their own challenging cases. The residents described the case as very thought provoking. They found it helpful to think about adolescent and young adult development in the context of a life-threatening medical illness, and useful to address the challenges of forming a therapeutic alliance during their inpatient stay. They expressed appreciation of having the perspective of the oncologist on the case with personal experience providing care to this patient population. They also indicated that they found the display of collaboration between the psychiatrist and oncologist helpful and inspiring. Residents indicated that the case conference afforded both thoughtful insight as well as reassurance to trainees regarding this inevitable and painful experience that they would encounter during their careers as psychiatrists. Most of the residents reported that they “loved!” having the patient present and hearing about the patient perspective in a reflective manner.

**Discussion**

Psycho-oncology is a uniquely intersectional discipline and requires the provision of sophisticated clinical care that draws on knowledge of pediatric oncology, general pediatrics, psychiatric assessment and treatment, and individual and family-based psychological interventions. The case conference involving the incorporation of a unique and specialized psycho-oncology team demonstrates an educational experience that modern students of medicine expect and deserve. The case-based teaching and resultant discussion created a space where the collaborative relationship between psychiatry and oncology could be actively demonstrated.

Adult learning theory tenets such as building on prior knowledge and especially creating the environment within which learning can occur were the backbone of this approach. The case-based model provided multiple opportunities for trainees to associate to their own clinical experiences and use questions to address areas of ambiguity or limitations in their own understanding. The flexibility of the case conference structure allowed trainees to guide the emphasis of the session. In our session, the focus became a rich discussion on the emotional responses to patient loss, the personal experience of the providers, and issues around resilience.
The inclusion of patient and family perspective enhanced the retention of the information by providing an evocative illustration of the real-life experiences of the individuals targeted by this intensive approach. A young adult patient and the parent of the deceased patient presented their first-hand experiences in their own words. The speakers brought to the forefront the experience of working with uncertainty, receiving bad news, and the experience of working with the treatment team. The trainees utilized the opportunity to ask more personal questions of the speakers to understand the unique challenges of this age group and what the patient and family found to be most helpful during the treatment while working with the 2 physicians. The parent responded to questions raised by the trainees in the areas of grief and bereavement and the family’s appreciation of the timeliness of discussing the poor prognosis with the medical team. This experience allowed the trainees to learn directly from their patients and aided them in becoming better physicians.

In response to the feedback, future sessions would include additional space for trainees to bring their own cases and clinical challenges for discussion. Further, additional input and training on the delivery of bad news is indicated and could include the use of patient simulations or role-plays to build on the existing case-based learning approach.

Conclusion
As physicians become further specialized, and necessarily more collaborative, it is important to model to trainees how multidisciplinary care teams practice and interact in the real world. By incorporating the above principals and interventions, the participating practitioners were able to demonstrate that the use of a multidisciplinary and patient-centered case conference is an engaging and memorable approach that provided students with a meaningful educational experience.

Take Home Summary
We implemented a case-based approach involving the incorporation of a unique and specialized psycho-oncology team and drawing on a corresponding set of educational principles to demonstrate the kind of educational experience that modern students of medicine expect and deserve.

References
About the Authors

**Zheala Qayyum, MD, MMSc**, is the Program Director for the Child and Adolescent Psychiatry Fellowship at Boston Children’s Hospital. She is the Assistant Clinical Professor of Psychiatry at Yale School of Medicine and faculty at Harvard Medical School.

**Asher Marks, MD**, is the Assistant Professor of Pediatrics (Hematology / Oncology) at Yale School of Medicine and director of Pediatric Neuro-Oncology. He is also the director of the adolescent and young adult (AYA) cancer program for Yale New Haven Children’s Hospital.

**Gerrit van Schalkwyk, MD**, is a child and adolescent psychiatrist, chief of the Adolescent Unit at Butler Hospital, and an assistant professor of psychiatry and human behavior, clinician educator, at the Warren Alpert Medical School of Brown University.

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Correspondence to Zheala Qayyum, MD; e-mail: zheala.qayyum@yale.edu

This article was edited by Anne McBride, MD.
As COVID-19 spread rapidly this spring, families throughout the country faced school closures. Suddenly, children have quite a bit of free time. Many children told me they were filling that time with video games, and I even saw this unfolding in my own home, where my husband suggested it was time to invest in more video games to entertain our children. Much to his dismay, I disagreed. I do not enjoy video games and have always felt hesitant to let our children play them. It was easy for me to enumerate the reasons why I was hesitant, but he challenged me to identify potential positives. I realized I knew very little about video games and it was time to remedy that knowledge gap. I decided that the online game Fortnite deserved some attention. To help me along the way I recruited 3 child psychiatrists (2 from Generation X and one baby boomer) and an incoming child and adolescent psychiatry fellow (representing Millennials) to play. Below is the journey that followed.

Before playing, I struggled more than I expected to even download the software and get the game running. When I finally started playing, I found it boring and quickly lost interest—the same reaction I had as a teenager when many video games had become quite popular. During our brief game I reflected on the technical skills the current generation have so seamlessly developed as well as the dramatically different world in which they will live. During my next patient encounter with a teen, I shared that I had recently played Fortnite. She was clearly delighted, particularly by my description of how badly I played. I still don’t like video games, but I must admit that the effort to engage in something my patients were interested in led to a more meaningful interaction with this particular teen patient. I was reminded of the importance of trying to understand the perspective of younger generations and acquired deeper appreciation for the skills they have in our increasingly digital world.

– Paula Wadell, MD, Generation X

Before Dr. Wadell invited me to play Fortnite, all I knew was that it was a shooter game (a game involving avatars engaging in combat with weapons) that many teens played for hours and hours. When I accepted the invitation, step 1 of my journey was to search the internet for “What is Fortnite?” My research revealed that it is a survival-shooter game where players fight off zombie-like creatures and build fortifications to protect stuff. But why the misspelling of the word “fortnight?” Another quick internet search yielded conflicting answers: one user reported that the game has nothing to do with fortnights and everything to do with building forts and surviving the night, while another noted that you actually do have to last 14 nights in “save-the-world” mode. I still don’t know the meaning behind the name of the game for certain as I quickly got bored of reading. With this extensive review under my belt, I decided I was now sufficiently prepared to play.

My 6-year-old son wasn’t so sure. When he saw me on the Fortnite website, he volunteered to explain what the game is about:

“So, um, first there’s like a batman mod and when you start playing the first Fortnite, the regular one you’re in, it’s kind of like PUBG. Because in PUBG you take an airplane.”

To which I replied, “But how do you know what PUBG is?” (I knew that PUBG is a different shooter game.)

“Because I played it on grandpa’s iPad. And Fortnite you kind of do the same thing but not in an airplane.”

When I told him about the looming game with my colleagues, he begged me relentlessly to play. Although he had never played Fortnite, he had once attended a family gathering where he watched another child play. I had previously been opposed to him playing any shooter game, particularly one labeled “teen,” but I gave
in, knowing that he’d be well supervised. As I struggled to correctly download the game on my laptop, he easily and independently downloaded it on our PlayStation.

During the actual gameplay, he patiently taught me which buttons to press and often had to come find me each time I became lost. While I accidently picked up and examined my map in the midst of battle, he seamlessly slayed surrounding foes and revived me each time I was near death. It was a sobering experience to be so completely outdone by a 6-year-old. But boy, did we both have fun. My biggest revelation was that the game was really not as dangerous or offensive as I had imagined. My son was certainly not scarred by the experience. Rather, we found another way to connect, work as a team, and enjoy ourselves.

– Anne McBride, MD, Generation X

I really enjoyed playing Fortnite with everybody. I have a fair amount of experience playing video games as I play a few hours of video games every Monday night with some friends (one who is local and 2 that live too far away to hang out in person) and I think it’s a great way to hang out, especially during a lockdown. Though I hadn’t played Fortnite before, I had played a few hours of other battle-royale shooter games.

I found the actual gameplay of Fortnite to be fun and not too complicated. The cartoony graphics make it clear that the premise of everyone killing each other is make believe. To me, it felt more like a nerf gun battle than actual warfare, which is probably a good thing for all the kids who play. The user interface is not simple and it prevented those of us who hadn’t played many video games from entering the game easily and joining with the team. Many parents will likely need their kids to teach them how to play. While the game itself is free, it constantly advertises upgrades to players, which is both annoying and probably bad for kids.

I enjoyed playing with Dr. McBride’s young son and I could see Fortnite being a fun game to play with my own kids as well as a useful game to play with patients given I had the technological capacity. There are all sorts of opportunities to work together, let each other down, heal each other, and experience loss or victory together that could be useful to talk about after playing. That being said, the competitive nature of the game, including getting shot and eliminated, would likely be too overwhelming for the more perfectionistic and anxious of my patients.

– Erik Youngdale, MD, Generation X

Though I probably won’t play Fortnite again on my own, it was undeniably fun to play with the faculty and their children in a process of shared discovery. The variety of ages and video game experience really made for some memorable moments, including “VeryOldBob,” the Baby Boomer of the group, being relegated to observer status after being unable to get the game running, Dr. Wadell getting stuck looking up at the sky (admittedly one of the better visual experiences rendered by my ancient graphics card), and Dr. McBride’s son quickly surpassing all of us in skill level despite also never having played before. While a child is more likely to be playing with same-aged and similarly skilled peers, Fortnite is clearly fertile ground for kids to make fun memories with their friends while developing skills in teamwork, organization, communication, and dealing with success and failure.

There is an uncomfortable level of violence in Fortnite, but given all of the gore-filled games available to kids, the cartoonish weapons and combat of Fortnite are on the more harmless end of the range. My biggest qualm with the game, which both detracted from my enjoyment and concerns me for children playing, is the frenetic organization of the user interface (on PC). Opening Fortnite and navigating to actually joining a game was frankly a nightmare. There were several distracting, seemingly pointless screens with myriad opportunities to spend money on “upgrades.” Once I finally made it to the main menu, I found a collection of various buttons and other clickable objects with unclear functions. The button to begin playing was undersized and tucked at the top of the screen. The whole thing felt overly designed to exploit the short attention spans and
addictive tendencies of vulnerable children. If played in moderation, I believe kids can get some of the benefits without suffering from the negatives, but parents need to be vigilant about how much time their children are spending playing this game.

– Shreesh Prasad, MD, a Millennial

References

About the Authors
Paula Wadell, MD, is an associate clinical professor of psychiatry at UC Davis. She is the associate program director for the Child and Adolescent Psychiatry Fellowship and the medical director for the UC Davis early psychosis programs.

Anne McBride, MD, is a child and adolescent and forensic psychiatrist at the University of California, Davis Medical Center. She is the program director for the child and adolescent psychiatry fellowship. Her interests include children’s mental health and juvenile justice.

Erik Youngdale, MD, is a child and adolescent psychiatrist with the University of California, Davis Department of Psychiatry and Behavioral Sciences in Sacramento.

Shreesh Prasad, MD, is a child and adolescent psychiatry fellow at the University of California, Davis Medical Center, Sacramento. His interests include forensic psychiatry, early psychosis, neurodevelopmental disorders, and trauma.

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If you are interested in writing for Connect Corner or if there is something you would like to see reviewed, please feel free to reach out to connect@jaacap.org with your suggestions!
**Author Guidelines**

JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our previous editions, the topic and format can vary widely, from neuroscience to teen music choices. What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate.

Authors are strongly encouraged to submit an initial outline to the editors, so that early feedback and guidance can be provided prior to the development of a full manuscript. An invitation to submit does not ultimately assure acceptance of the manuscript.

**Manuscript Format**

For full details regarding manuscript format, such as word count and required submission components, please see the Author Guidelines for JAACAP Connect, found here.

**Peer Review and Mentorship**

Outlines and manuscripts will be reviewed by the editors, editorial board members, and select experts. We recognize that mentorship for manuscript authorship may not be available to everyone. We will work with students, trainees, early career, and seasoned physicians, regardless of previous publication experience, to develop brief science-based and skill-building articles.

**Submission/Contact**

More information is available at [http://www.jaacap.com/content/connect](http://www.jaacap.com/content/connect) under the “Submit” tab. Please send inquiries, potential topics, outlines, and draft articles to connect@jaacap.org.