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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.
Transitions

Transitions are on my mind. As I write this, summer break is coming to an end and the new school year is near. For my own family and the children and families we work with, this particular transition can be both exciting—embarking on a new journey while often reconnecting with peers—and challenging. As a provider working in a children’s mental health crisis setting, I typically observed an increase in crises that coincided with the transition into the new school year. This year, and throughout the pandemic, transitions in the mental health field have seemed more salient. In each of the mental health settings where I work, I notice that staffing has decreased, turnover has increased, and providers are increasingly examining their own goals and values, leading to more transitions. Amongst my colleagues, this has included transitions both into and out of academic child psychiatry, which has been both exciting and challenging for me personally. For some transitions, “bittersweet” is an appropriate descriptor.

For JAACAP Connect, Volume 9, Issue 3 represents my penultimate issue as Connect editor. We welcomed J. Corey Williams, MD to the JAACAP team in late 2021 when he was selected as the 2022-2023 John F. McDermott, MD, Assistant Editor-in-Residence and Associate Editor of JAACAP Connect. His transition into the JAACAP team has already been remarkable. He brought fresh perspective and valuable insights, and with his focus on justice, equity, diversity, and inclusion, I am continually grateful to learn from him. When he transitions into the role of JAACAP Connect Editor in January, 2023, Connect will continue to grow stronger.

We lead off the issue with an article by Dr. Shaligram, entitled, “Educate, Innovate, and Advocate Through Writing: Three Must-dos for Every Trainee.” Dr. Shaligram reminds us why many of us gravitated towards child psychiatry and how writing can be a powerful tool used to tell our patient’s story, educate others, harness creativity, and advocate for important policy issues within the field. We next move into the clinical world, as Dr. Hannah E. Johnson and colleagues present findings from a pilot study examining psychotropic medication prescriptions for inpatient transgender and cisgender adolescents. The authors highlight the need for adequately powered studies with transgender adolescents given the higher risk for mental and physical health complications and treatment disparities compared to cisgender adolescents.

Dr. Burgundy Johnson et al. provide a great summary of attachment theory and its relevance to clinical practice in child psychiatry. The authors invite clinical providers to bolster their practice with increased awareness and intentionality around use of the attachment theory framework. Next, Mr. Sharma addresses an important issue in child psychiatry that involves the interplay between digital technology and sleep in adolescents, and how the COVID-19 pandemic has heightened the negative impact. He provides guidance for the clinician and underscores the opportunity for change from a public health perspective. In the next article in our Spotlight on Juvenile Justice series, Dr. Salem and colleagues provide an overview of understanding trauma within the juvenile justice system, a critical topic given that the vast majority of juvenile justice-involved youth have experienced life-threatening trauma.

The last 3 articles draw connections between media and youth. Drs. Gearin, Grech, and Dolan review songs with suicide references in the United States, and discuss various clinical applications. The clinician is asked to reflect on both the positive and negative impact that songs may have on youth, and the authors provide guidance for child psychiatrists. Next, Drs. Lau, Lin, and Sust analyze Pixar’s movie, Soul, in the Connect Corner column, offering suggestions for parents when faced with discussions with their children on the topics of death and spirituality. Finally, in his recurring Lab to Smartphone column, Dr. Rettew provides a nuanced
look at child-directed diagnosing, the possible relationship with social media, and how clinicians may consider a developmentally appropriate path forward. The articles in this issue are richly diverse in scope and topic and represent thoughtful work from multiple early authors. As we continue through the natural transitions of life, I hope you find time to read, reflect, and enjoy.

Anne B. McBride, MD
JAACAP Connect Editor

Follow @AACAP for the latest news on your membership and in child and adolescent psychiatry.

Follow @JAACAP for updates about newly published articles and all things #jaacap.
The love of a story is something that we all share as child psychiatrists. I loved reading stories as a child. While growing up in India, stories let me explore the world and consider a variety of viewpoints. In medicine what I enjoyed the most was to listen to someone's story and see the whole person in the context of their experiences and diagnoses. Storytelling skills are at the core of writing clinical notes and critically evaluating papers and creating a biopsychosocial formulation. Writing good biopsychosocial formulations serves the purpose of documentation, analysis of clinical and research observations, and fosters engagement and reflection in clinicians during medical education and beyond.

The Role of Writing in Medicine
Writing in medicine spans the gamut of communication with patients, peers, teachers, paraprofessionals, managed care, ancillary organizations, policymakers and the community at large. As a pedagogical approach, narrative writing in medical education comprises acts of close reading, diagnostic listening that enlist the physician's curiosity, bearing witness, generating and weeding through differential diagnoses, analyzing clinical and laboratory findings with accuracy, reflective writing, and authentic discourse with patients. Narrative writing has been shown to increase empathy, create meaningful patient-physician relationships and deepen a sense of affiliation with colleagues, teachers, and self. Scholarly writing in academic medicine encompasses writing research-related proposals, abstracts for conferences, manuscripts for publication in journals, disease or drug-related educational materials, content for healthcare websites and regulatory, policy and advocacy-related papers. Scholarly writing is traditionally encouraged to disseminate knowledge and to propel professional advancement in academics. But whether one chooses a career in academics or private practice, writing keeps clinical skills sharp by ensuring that physicians read and stay abreast of current literature. Further, advocacy through writing is an essential tool for child psychiatrists to speak up for vulnerable and marginalized children, and those afflicted with mental illness. Writing for media, especially social media, can be effective in educating families about mental health and advocating for societal engagement. Lastly, writing can be a creative and cathartic outlet; nurturing that inner muse is particularly important for child psychiatrists to practice playfulness, find fulfillment, and seek succor. Developing writing skills as an integral part of every trainee's academic journey and inculcating the mantra "educate, innovate, and advocate through writing" would enable trainees to maximize their contributions to the field.

Educate Through Writing
Writing presents a unique platform for trainees interested in teaching. Trainees can educate through scholarly writing by highlighting an unusual clinical presentation or side effect. Another opportunity for trainees to teach through writing includes utilizing the fundamentals of critical review in the form of a letter to the editor in response to a journal article. Drawing from the traditional wisdom of “write what you know” trainees can play to their strengths and harness their existing skill set to capitalize on low hanging fruit to launch into their teaching (writing) career. For trainees who are passionate about education, scholarly writing can extend their impact beyond their immediate circle to a far wider audience.

Innovate Through Writing
Writing can help trainees (and even experts) ponder complex issues, engage others in defining a problem
and design novel solutions. An example of innovation during training is the development of a clinical scholarship project. When trainees plan for publication of their clinical scholarship project after presentation within the training program, they can effectively disseminate the value of their innovation. Letters to the editor may also be an avenue for trainees to spearhead micro-innovations. Reporting a new observation or raising questions about the methodology and findings of a study through letters to the editor, allows for the next iteration of a study to build on critical suggestions and address identified limitations.

**Advocate Through Writing**

By putting thoughts and experiences into writing, trainees can raise awareness about pertinent issues in our field and pave the way for moving the needle. The AACAP Legislative conference is an example of an excellent venue for trainees to practice advocacy by writing to elected officials on social media. JAACAP’s Book Forum column offers another platform for trainees to critique books while voicing opinions and championing causes dear to them. It is a fun way of polishing writing skills while practicing advocacy. *AACAP News,* *JAACAP Connect,* and *American Journal of Psychiatry Residents Journal* have trainee-friendly opportunities for advocacy that builds on the breadth of diagnoses, systems and policy issues introduced during fellowship. They also offer helpful resources for the aspiring author and advocate, such as the art of writing an engaging abstract, how to find and keep a good mentor, and the “Knowledge Skills Attitudes” model to overcoming “energy” barriers to writing.

Finally, finding and emulating a good mentor is key to learning the crafts of teaching, research and advocacy through writing as a trainee. To draw on the persuasiveness of Andrés Martin, MD, doyen of mentors, “You may not know it, and someone early in his or her career may not believe it, but the fact is that someone wants to read your work, and there is a home for it. Only one thing is for certain: if you don’t get started and give it a real try, then your work will never be published. Writing is hard work, but it is also a skill you can learn and one that gets better with practice and time... You have a story to tell, and someone out there wants to hear it. So get started and down to business. Roll up your sleeves. Just do it!”

To sum up, trainees should consider education, innovation and advocacy through writing as essential components of their career path during and after medical education. Every trainee has something to offer and every voice matters. Viewing education, innovation, and advocacy as developmental stages in training may help steer trainees’ growth as educators, innovators and advocates through writing. When trainees increase their familiarity and facility with writing, they invest in their patients, their work and the development of our young field.

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**Take Home Summary**

Developing writing skills should be an integral part of every trainee’s academic journey. Viewing education, innovation, and advocacy as developmental stages in training may help steer trainees’ growth as educators, innovators, and advocates through writing.

**References**


About the Author
Deepika Shaligram, MD, is an attending psychiatrist at Boston Children’s Hospital/Harvard Medical School and the Massachusetts Child Psychiatry Access Program. Her interests include improving access to care, training/education, and social justice.

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Disclosure: Dr. Shaligram has reported no biomedical financial interests or potential conflicts of interest.

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This article was edited by Michelle Horner, DO.
Comparing Psychotropic Medication Prescriptions for Inpatient Transgender and Cisgender Adolescents

Hannah E. Johnson, PharmD, Natalie N. Gray, PharmD, Aric Schadler, PhD, TK Logan, PhD, Kristen Mark, PhD, MPH, Kelly K. Hill, MD

Transgender and gender nonconforming (TGNC) adolescents, defined as individuals whose gender identity does not align with sex assigned at birth, are at higher risk for mental and physical health complications and disparities compared to cisgender adolescents. TGNC individuals report negative health-care experiences which can lead to avoidance of further medical care. Examples include use of wrong pronouns (misgendering), not calling patients by their updated name (deadnaming), being treated as an investigation instead of as human (probing), provider-imposed barriers to care (gatekeeping), and stigmatizing stances such as feeling unwelcomed by the provider. Additionally, studies reveal higher rates of suicide behaviors in TGNC compared to cisgender adolescents.

Therefore, services aimed at assessment, monitoring, and treatment of mental health conditions for TGNC adolescents are of priority and need to be evaluated. Little has been published on treatment of mental health conditions in TGNC adolescents and how this compares to cisgender adolescents. We sought to evaluate psychotropic medication prescriptions for TGNC compared to cisgender adolescents admitted to an inpatient behavioral health unit (BHU).

This study of secondary data analysis was approved by the University of Kentucky Institutional Review Board. Electronic medical records (EMR) of patients ages 12 to 18 admitted to a 10 bed university-based inpatient behavioral health unit were searched for keywords: trans female, trans male, nonbinary, gender dysphoria, transgender, transgender female, and transgender male.

Patients with records containing any keywords were classified as TGNC. Records without gender identity were excluded. Identified TGNC patients were matched by age, gender identity on admission, ethnicity, and mental health diagnoses, collected using International Classification of Diseases, Ninth and Tenth Revisions (ICD-9, ICD-10) codes, to cisgender patients.

Prescription medications were extracted and classified as home or discharge medications. Home medications, prescribed by outpatient provider(s), were obtained from the patient’s medication list (including names and dosages) documented on admission by a pharmacy technician or pharmacist. Discharge medications were obtained from discharge order reconciliation and summary documents.

Statistical analyses, using IBM SPSS Statistics v.5, included: descriptive statistics (demographic information); Pearson’s Chi-square and Fisher’s Exact Tests (to compare diagnoses and prescribed medications between TGNC and cisgender patients); Analysis of Variance (ANOVA) (to compare groups on continuous variables).

Between January 1, 2012, and October 14, 2018, 2,294 patients were admitted to our BHU. Twenty-six patients were identified as TGNC (Table 1). Over the study period, there were 3 TGNC-identified patients from 2012-2015 and 23 from 2016-2018 (see Figure 1 for further details). The most common diagnoses were major depressive disorder and unspecified anxiety disorder. Sixteen (61.5%) TGNC patients had attempted suicide at least once compared to 12 (46.1%) cisgender patients, averaging 1.19 and 0.73 attempts, respectively. There was no statistical difference between suicide attempts ($p = 0.714$) or documented self-harm. There was also no significant difference in prescribed medications on admission or discharge. One patient was actively taking gender-affirming hormone therapy.
### Table 1. Demographic Data and Comparison of Mental Health Diagnoses and Prescribed Psychotropic Medications of Match-Paired Transgender and Gender Nonconforming (TGNC) and Cisgender Patients Admitted to an Inpatient Behavioral Health Unit

<table>
<thead>
<tr>
<th></th>
<th>TGNC (n = 26)</th>
<th>Cisgender (n = 26)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, mean (SD)</strong></td>
<td>14.9 (1.75)</td>
<td>14.8 (1.74)</td>
<td>0.937</td>
</tr>
<tr>
<td><strong>Race/ethnicity, n (%)</strong></td>
<td></td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>White</td>
<td>24 (92.3)</td>
<td>24 (92.3)</td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>2 (7.7)</td>
<td>2 (7.7)</td>
<td></td>
</tr>
<tr>
<td><strong>Gender identity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisgender</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male-to-female</td>
<td>4 (15.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female-to-male</td>
<td>18 (69.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonbinary</td>
<td>4 (15.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient diagnoses, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>23 (88.5)</td>
<td>24 (92.3)</td>
<td>1.000</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>2 (7.7)</td>
<td>0 (0.0)</td>
<td>–</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>7 (26.9)</td>
<td>5 (19.2)</td>
<td>0.510</td>
</tr>
<tr>
<td>Unspecified anxiety disorder</td>
<td>18 (69.2)</td>
<td>16 (61.5)</td>
<td>0.565</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>4 (15.4)</td>
<td>2 (7.7)</td>
<td>0.668</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>0 (0.0)</td>
<td>1 (3.8)</td>
<td>–</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0 (0.0)</td>
<td>1 (3.8)</td>
<td>–</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1 (3.8)</td>
<td>0 (0.0)</td>
<td>–</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>–</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>4 (15.4)</td>
<td>4 (15.4)</td>
<td>1.000</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>3 (11.5)</td>
<td>3 (11.5)</td>
<td>1.000</td>
</tr>
<tr>
<td>ADHD</td>
<td>6 (23.1)</td>
<td>10 (38.5)</td>
<td>0.229</td>
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<tr>
<td>Substance use disorder</td>
<td>0 (0.0)</td>
<td>4 (15.4)</td>
<td>0.110</td>
</tr>
<tr>
<td>Suicide Attempts, mean (range)</td>
<td>1.19 (1-11)</td>
<td>0.73 (1-3)</td>
<td>0.714</td>
</tr>
<tr>
<td>Self-Harm, mean (range)</td>
<td>13 (50.0)</td>
<td>16 (61.5)</td>
<td>0.577</td>
</tr>
<tr>
<td><strong>Home medications, n</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSRI(^b)</td>
<td>15</td>
<td>13</td>
<td>0.578</td>
</tr>
<tr>
<td>SNRI(^b)</td>
<td>1</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>TCA(^d)</td>
<td>0</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Atypical(^b)</td>
<td>2</td>
<td>3</td>
<td>1.000</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>4</td>
<td>4</td>
<td>1.000</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First generation</td>
<td>0</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Second generation</td>
<td>3</td>
<td>3</td>
<td>1.000</td>
</tr>
<tr>
<td>Mood stabilizer</td>
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<td>5</td>
<td>0.191</td>
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<tr>
<td>Stimulants</td>
<td>2</td>
<td>4</td>
<td>0.668</td>
</tr>
<tr>
<td>(\alpha-1) adrenergic antagonists</td>
<td>1</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>(\alpha-2) adrenergic agonists</td>
<td>0</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>Over-the-counter</td>
<td>1</td>
<td>2</td>
<td>1.000</td>
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<tr>
<td>Hormone therapy</td>
<td>1</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Sleep aids</td>
<td>3</td>
<td>4</td>
<td>1.000</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>1.3</td>
<td>1.6</td>
<td>0.406</td>
</tr>
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</table>
This study serves as a pilot to future studies about the inpatient mental health care of TGNC and cisgender adolescents. We did not see differences in prescribing patterns when TGNC and cisgender adolescents were matched by diagnosis; however, due to the high risk and mental health disparities, adequately powered studies are needed to further evaluate mental health identification, diagnosis, and prescribing patterns in TGNC adolescents.

While there was an increase in the number of TGNC adolescent admissions over the study period, this may represent evolving awareness and improvement in recognition of gender diversity. However, the number of TGNC adolescents may be under-reported. Importantly, the nature of chart review revealed many inconsistencies in EMR documentation that are worth noting. Many patients’ gender identity was undocumented, which could have caused many TGNC patients to not be identified. This could be due to discomfort or bias of the clinician, lack of training or awareness, or systematic barriers to appropriate documentation and interviewing. The EMR does not have specific requirements or constancy in documenting gender identity, pronouns or updated name. This information is dispersed throughout the EMR and not easily available. Without a consistent way or requirement to assess or document these, healthcare providers are at risk of precipitating negative experiences, such as misgendering or deadnaming. Furthermore, patients were only identified as TGNC if they willingly provided that information. Adolescents with gender dysphoria may not disclose this information, especially if previous negative experiences have occurred or parents/caregivers are present. We likely missed additional TGNC patients

<table>
<thead>
<tr>
<th>Discharge medications, n</th>
<th>TGNC (n = 26)</th>
<th>Cisgender (n = 26)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSRI(^b)</td>
<td>15</td>
<td>14</td>
<td>0.78</td>
</tr>
<tr>
<td>SNRI(^c)</td>
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<td>TCA(^d)</td>
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<td>0</td>
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<tr>
<td>Atypical(^e)</td>
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<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Second generation</td>
<td>4</td>
<td>6</td>
<td>0.726</td>
</tr>
<tr>
<td>Mood stabilizer</td>
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<td>4</td>
<td>0.350</td>
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<tr>
<td>Stimulants</td>
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<td>4</td>
<td>0.350</td>
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<tr>
<td>α-1 adrenergic antagonists</td>
<td>4</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>α-2 adrenergic agonists</td>
<td>0</td>
<td>3</td>
<td>—</td>
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<tr>
<td>Over-the-counter</td>
<td>2</td>
<td>1</td>
<td>1.000</td>
</tr>
<tr>
<td>Hormone therapy</td>
<td>1</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Sleep aids</td>
<td>4</td>
<td>5</td>
<td>1.000</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>1.6</td>
<td>1.8</td>
<td>0.558</td>
</tr>
</tbody>
</table>

Note: ADHD = attention-deficit/hyperactivity disorder.
\(^a\)Based on \(\chi^2\) and Fisher’s Exact
\(^b\)Selective serotonin reuptake inhibitors
\(^c\)Serotonin-norepinephrine reuptake inhibitor
\(^d\)Tricyclic antidepressants
\(^e\)Atypical antidepressants (including bupropion and mirtazapine)
in our study for that reason. To ensure equitable and unbiased mental health care for all patients, it is essential to train healthcare providers, ensure competency in gender diversity, and ensure consistent interview and documentation processes for patients as they enter our healthcare systems.

**Take Home Summary**

We did not see differences in prescribing patterns between inpatient transgender and gender nonconforming (TGNC) and cisgender adolescents. However, TGNC adolescent admissions increased over the study period which highlights the need for training on equitable and unbiased mental health care.

**References**


About the Authors

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Utilizing Attachment Theory in Clinical Practice

Burgundy Johnson, DO, Nikki Mathur Grunewald, MS, PhD Candidate, Kelly Pelzel, PhD, Elizabeth Jarvis, MD

Mary Ainsworth and John Bowlby described attachment as “a deep and enduring emotional bond that connects one person to another across time and space.” Evidence-based psychotherapies employing constructs from attachment theory have gained traction in early childhood mental health, though attachment is not often consciously considered when it comes to formulating clinical impressions during appointments. This is not to imply that providers are not meeting the attachment needs for families they serve, but rather that increased awareness of attachment processes offer insight into what makes relationships work and how to make the therapeutic alliance stronger. For example, the reassurance a provider gives that allows a patient to explore their relationships and feelings is promotive of the attachment relationship. Often this leads to a reduction in anxiety and improvement in functioning. Sometimes by telling the anxious patient that they can find help in therapy and medications, that there is a reason and treatment for their pain and worries, and that they are not “stuck forever” can make a huge difference. To that end, this article seeks to provide basic information on attachment theory and how it can be used therapeutically during clinical appointments.

History of Attachment Theory

The work of John Bowlby and Mary Ainsworth propelled attachment theory and research. John Bowlby (1907-1990), a child psychiatrist and psychoanalyst, postulated that an infant’s attachment system serves to keep an infant close to the mother when under threat, thus improving the child’s chances of survival. Bowlby believed early attachment experiences with an attachment figure heavily influenced how individuals perceive themselves and relationships long-term. Briefly put, “When a child develops a secure attachment, they see themselves as good and loveable and the other as responsive, available and loving...if they develop a model of the self as unworthy of love... or worthless and the other as unavailable or threatening, then the child develops an insecure attachment style.” He worked in tandem with developmental psychologist Mary Ainsworth (1913-1999). She expanded on attachment theory and one of her contributions was the idea of patterns of attachment: secure, insecure avoidant, and insecure ambivalent/resistant. Infants with an insecure avoidant pattern learn that their best strategy for keeping their caregiver close in stressful situations is to minimize outward distress and to display interest in exploring the environment. In contrast, infants with an insecure ambivalent/resistant pattern learn their best strategy for keeping their caregiver close in stressful situations is to minimize exploration and to increase outward distress (despite attempts to comfort and soothe). Ainsworth described how interactions in infancy formed these patterns, which led to her design of the brief separation-reunion procedure called the Strange Situation. A fourth attachment classification, disorganized, was later conceptualized. Disorganized attachment is characterized by a lack of a coherent, organized strategy to keep the caregiver engaged. In some ways, disorganized attachment is the lack of a pattern of attachment. While secure and insecure attachments are more common in society than disorganized attachments, there is a disproportionally large number of children with disorganized attachments seen in psychiatry. Often there is a high correlation between trauma and disorganized attachment.

Mental Health Providers as Attachment Figures

Clinical providers often become attachment figures for patients and their parents. Attachment-informed practice does not mean conducting a specific type of psychotherapy, but rather having perpetual curiosity about attachment and what role it plays in relationships.
To promote secure internal working models of attachment, providers can consciously work to maintain a stance that is regulating, non-threatening, sensitive, synchronous, mentalizing, and radically accepting. These are approaches that many providers are already utilizing, though we argue that clinical practice can be bolstered with increased awareness and intentionality. In order to provide a secure base to patients, providers must not only be curious about others’ attachment states, but their own as well. In reflecting on their own histories and relational state of mind, providers increase their own and patients’ mentalizing capacity too. Providers willing to understand their own attachment history can provide a more stable base for their patients because they are more aware of how their own relational needs impact the provider-patient relationship.

**Intersubjective Relatedness and Mentalizing States**

Intersubjective relatedness or intersubjectivity can be understood as sharing intentions and feeling states. Mentalizing is viewed as a manifestation of intersubjectivity and is a process that allows people to understand and make meaningful sense of their experience and that of others. Intersubjectivity is driven by the need to know and be known by others whereas attachment is driven by the need for security. Attachment and intersubjectivity complement each other—attachment facilitates security, intersubjectivity for belonging.

Further, intersubjectivity allows us to understand others by joining in, being with, or sharing the subjective experience of another person with no attempt to change it. It requires mutual regulation and recognition; allowing for two distinct, independent personal experiences while maintaining the ability to recognize and be recognized by the other. Within this, there are two broad experiences—intersubjective and intrapsychic. For the intersubjective experience (“I-Thou”), the other is outside one’s mental field as a separate subject, while for the intrapsychic (“I-it”), mutuality is absent and the other exists within one’s mental field as a product of the person’s preexisting categories of people. Recognition of these two processes within the therapeutic working relationship allows a more regulated exchange between practitioner and patient—asserting one’s own reality and accepting the (potentially) opposing reality of another. This lifelong process increases flexibility and willingness to experience the world from another’s perspective while continuously being aware of one’s own attachment and interactional style. When practitioners mentalize, they can more consciously and intentionally respond to others as individuals with specific and unique needs.

**Tying Together in a Case Study**

Ashley, a 14-year-old female with the complaint, “I think I have schizophrenia” presented for psychiatric evaluation of somatic symptom disorder. Hyperfocused on perceived limitations, Ashley pushed others away confirming to herself that she was broken. Feeling misunderstood, she pushed providers away. Like Ashley, insecurely attached (ambivalent/resistant) individuals increase outward distress in response to immense internal struggle.

Attachment informed therapy guided Ashley’s care drawing connection between her insecure attachment and symptom perseveration. Through this process, mentalization improved and rigid defenses softened. A general attitude of curiosity was the foundation, such as, “I wonder why you think that,” or, “I wonder what this was like for you.” Instead of meeting resistance, she was praised for showing resilience. In turn, treatment engagement led to more focus on developmentally appropriate discussions about her life, and improved school and relationship outcomes. By approaching her in a regulating way, her pathological symptoms decreased, and she had improved functioning.

**Points to Keep in Mind**

Learning about attachment theory and reflecting upon one’s personal attachment history can evoke uncomfortable feelings for providers. Use of attachment theory in clinical practice requires vulnerability from the provider to examine their own relational style and attachment.
experiences. The following are some aspects to keep in mind when thinking about attachment theory.

First, the information in this article should be considered an introduction and brief summary. What is known about attachment and its clinical utility is rich and continues to evolve as investigators test and refine this theory. With that in mind, the most useful step to immediately take may be to simply start thinking about it as part of clinical practice. Just as providers consistently consider the biopsychosocial aspects of a case, they can also recognize attachment, including their role in promoting attachment security.

Next, to paraphrase Winnicott, it is important to remember there is no such thing as being a perfect parent. Neither is there a perfect doctor, a perfect teacher, a perfect partner, etc. It is important to pause judgment and demonstrate grace, while approaching relationships with curiosity so as not to diminish the capacity to mentalize.

Finally, secure relationships can be restorative for individuals classified as insecure or disorganized. Ongoing experiences in close relationships influence internal working models. Mental health providers have the chance to provide restorative experiences to patients, coworkers, trainees, and others by observing how they interact with others. It is amazing that by exploring and being curious about how we individually connect to others, we can ultimately help others build better relationships.

Take Home Summary
The application of attachment theory to clinical medicine is a meaningful and relevant method for conceptualizing cases. While many clinicians instinctually apply attachment principles when working with patients, providers' intentional use of attachment theory can improve patient care by both understanding their own attachment style and being able to identify that of their patients. Conscious awareness and use of attachment processes, such as mentalization, intersubjective relatedness, and attachments to mental health providers can allow clinicians to connect with patients more effectively, efficiently, and meaningfully across a variety of contexts.

References
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This article was edited by Misty Richards, MD, MS.
The COVID-19 pandemic has resulted in a large technological shift in the processes of daily life. School and work, if possible, are now virtual along with most social interactions. While it is fortunate that this digital technology allows adolescents to overcome academic and social limitations, it is crucial to recognize that it may also have side effects. Adolescence is a sensitive developmental period accompanied with a number of difficult transitions, which the increased reliance on digital technology during this pandemic might exacerbate.

The majority of US teenagers spent more than 4 hours a day on screen media\(^1\) prior to the pandemic. Since its start, this number has increased drastically as schools shift to an online format and safety protocols force adolescents to rely more heavily on social media to interact with the world. This maintains some of the benefits of social interactions in a physically distanced world; however, the possible overuse of digital technology can come with repercussions as the youth’s reliance on technology continues to increase in trying to navigate sudden changes in daily routine and they seek to build peer relations, maneuver emerging relationships, and develop self-identity. Research has demonstrated a bidirectional link between greater digital technology use and shorter sleep time in adolescents;\(^2\) thus, it is paramount to focus on this relationship since sleep impacts adolescent mental health.

Due to limited physical contact, a phenomenon of “fear of missing out” (FOMO) may be more prevalent during the pandemic, as adolescents harbor preoccupation regarding others having more rewarding experiences than oneself, and feel the need to belong through constant engagement on social media platforms.\(^3\) The more time an adolescent spends on social media, the more active this thought of “What am I missing out on?” becomes, eventually manifesting as overwhelming stress and anxiety. As we shift to a virtual world, the FOMO also shifts from what a person is missing out on by not physically being there to what they can miss by not being on the phone. This exacerbates sleep difficulties as it becomes much harder to disengage from the virtual world at the end of the day. Also, when one does disengage, the FOMO can increase and this is linked to increased sleep issues.\(^4\)

Juggling between online school, leisure activities such as videogaming or watching television, and social media for extended periods of the day exposes adolescents to effects of blue light emitted by the technological devices. This is linked to suppression of melatonin production and delay of sleep onset.\(^4\) To counteract the effects of stress, the hypothalamic pituitary axis produces cortisol, a stress hormone, which may contribute to possible homeostatic imbalances and appear as sleep difficulties. Blue light has been shown to elevate cortisol levels, suggesting an increased fight or flight response while lying in bed for those engaging in device usage,\(^4\) causing fragmentation of sleep and shortened sleep time. Since screen time influences brain circadian rhythm, causing sleep out-of-phase, it is theorized that increased digital technology usage during the day and night can be used to predict increased sleep difficulties.

Sleep is a physiological process that has been shown to have restorative and regulatory properties. Interestingly, even normal biological, psychological, and social changes that occur during adolescence predispose them to insufficient sleep and tiredness.\(^5\) Research has demonstrated that when adolescents and children sleep for the same number of hours per night, adolescents report higher rates of sleepiness during the day, supporting the idea that adolescents may have a greater sleep need.\(^6\) Symptoms of sleep difficulties affect
approximately one fourth of adolescents as exhibited in several large epidemiological studies.7

The ongoing pandemic-related overuse of digital technology has resulted in increases in sleep difficulty,8 leading to surges of cortisol levels over extended periods of time, potentially impairing innate immune function and making adolescents susceptible to infections such as the COVID-19 virus.9 The increased vulnerability to the virus is intriguing, as different Coronavirus strains have been linked to mental health disorders.10 This may contribute to more mental health problems in adolescents even though the physical severity of COVID-19 illness manifestations may be relatively mild.

Partial sleep loss on a chronic basis accumulates into a sleep debt, which can produce significant neurobehavioral impairment.11 In addition, sleep problems predict development of emotional and behavioral issues in later life.12 It is well acknowledged that during adolescence, an individual acquires the physical, cognitive, emotional, social, and economic resources that build a critical foundation for later life, health, and well-being. Over a year (and counting) of physical distancing represents a large portion of an adolescents’ life during a sensitive period of development, so it is possible that the effects of sleep difficulties will be more long-term. This is especially true since adolescence is a period of heightened vulnerability to mental health problems. According to the World Health Organization (WHO), half of all mental illnesses begin before the age of 14.13

It can be speculated that the sleep difficulties experienced by adolescents may be a consequence of overuse of digital technology during the pandemic, as available research on the topic is limited. A possible explanation is that they are overusing digital media to overcome the varied psychosocial stressors related to COVID-19 safety protocols. It will be challenging to restrict overuse of digital technology especially during the pandemic, as it has become one of the few effective ways to remain engaged in education and socialization, while allowing adolescents to practice autonomy from parental figures. Considering that sleep and mental health are two inseparably linked aspects of health,14 adolescents need support in balancing their online interactions with an appropriate and consistent sleep schedule in the present crisis.

Since sleep is often overlooked in public health messages and education interventions,15 the pandemic provides a great opportunity to structure our mental health system towards recognizing sleep-related issues, followed by increasing awareness and education about sleep hygiene as a preventative measure in this vulnerable population.

Sleep hygiene is understood as the degree of individual adoption of specific behaviors that promote sleep, in concurrence with avoidance of habits that inhibit sleep.16 Therefore, establishing appropriate times to disengage from the screen, setting up a calming and structured bedtime routine, having a regular sleep/wake routine, and using the bed only for sleeping is a reasonable approach to sleep improvement efforts. Studies have demonstrated that self-reported sleep issues in adolescents can be improved through practicing better sleep hygiene.17

As a relatively inexpensive lifestyle intervention, sleep hygiene education could serve as a first line of defense for adolescents in the present crisis and beyond. The utility of sleep hygiene education could be enormous since it can be disseminated easily and readily, even by non-clinicians. Thus, the role of educating and empowering parents and caregivers is also crucial. In one study, adherence to sleep hygiene was relatively high and increased over time compared to other treatments, providing support that once educated, people are likely to continue practicing good sleep hygiene.18 Furthermore, sleep hygiene recommendations can be delivered through digital media resulting in increased accessibility. As a highly relevant issue for pediatric practice, future research is needed to explore, inform and update the relationships among digital overuse-related stress, sleep, and COVID-19 to better understand the complex nature of its impact on mental health.
Take Home Summary

With increasing use of social media and digital technology during the pandemic, it is interesting to examine the effects this could have on mental health and sleep, particularly in vulnerable populations such as adolescents, as well as potential treatments.

References


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This article was edited by Duy Nguyen, MD.
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.

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Spotlight on Juvenile Justice: Understanding Trauma and Justice-Involved Youth

Amanie Salem, DO, MPH, Jasmine McClendon, MD, MPH, Marcia Mallorca, MD, MPH, Anne B. McBride, MD

Upon entering juvenile detention at age 16, Julian struggled to adjust. He was irritable, quick to anger with little provocation, and had difficulties sleeping and eating. He received write-ups for his behavior after involvement in fights with other residents. One of the fights led to additional charges filed for assault. Julian was evaluated for mental health symptoms and met criteria for posttraumatic stress disorder related to community violence exposure and severe cannabis use disorder. His mental health assessment revealed that Julian’s neighborhood had higher rates of community violence compared to other surrounding areas. When Julian turned 16, he witnessed one of his close friends die by firearm violence. Julian began to have nightmares and constantly felt on edge. He smoked marijuana more frequently and in greater quantities to help him sleep and avoid thinking about his friend’s death. He obtained a firearm from his friends and began to carry it around for protection.

Trauma is pervasive throughout the juvenile justice system. For justice-involved youth, child maltreatment is highly prevalent and vastly underrecognized. In a population of over 1,800 detained juveniles, 83% self-reported history of physical abuse; however, formal maltreatment court records existed for only 17% of youth self-reporting any abuse, 22% of youth self-reporting the most serious abuse, and 25% of youth self-reporting abuse that required medical attention. Overall, adverse childhood experiences (ACE) are overrepresented within juvenile justice. In the original ACE study of a large population of insured mostly college-educated adults, 36% reported zero ACEs and 13% reported four or more ACEs; in a population of 64,329 juvenile offenders in Florida, 2.8% reported zero ACEs and 50% reported 4 or more ACEs. More broadly, trauma is alarmingly common in juvenile justice as more than 90% of detained youth report exposure to life-threatening trauma, over half who experience 6 or more life-threatening traumas, and over 1 in 10 juveniles who meet criteria for posttraumatic stress disorder (PTSD) (most commonly related to witnessed violence). Additionally, mental health problems that frequently co-occur with trauma exposure are prevalent in detained youth, such as substance use disorders, depression, anxiety, and suicidal thoughts and behaviors.

Trauma exposure can profoundly affect neurodevelopment. Models of emotional development illustrate that in typically developing youth, emotional reactivity to negative stimuli declines and regulatory capacity increases with age. Current neural models implicate various regions of the brain, including the dorsolateral prefrontal cortex, amygdala, and hippocampus, in the regulation of emotional reactivity. Childhood trauma may influence the development of these regions, increasing the risk of affective disorders for these youth and resulting in dysfunctional development of fear-related neurophysiological patterns affecting emotional, behavioral, cognitive, and social functioning. Persistent activation of the stress response system, the hypothalamic-pituitary-adrenal axis, can lead to increased levels of adrenaline and cortisol through the body, and this overactivation may influence the changes in the structure of the brain.

Retrospective surveys of adverse experiences and prospective studies of maltreatment find that children who experience trauma are at risk of poorer developmental and health outcomes because of direct harm through injury, indirect harm from insecure attachment, lack of positive stimulation and modeling behavior critical to development of the early brain, and taxing of neurobiological responses related to stress. The clinical consequences of these traumatic events may affect
children differently because of the varying stages of neural development, but many of the effects of trauma on youth can be understood as efforts to minimize threat and regulate emotional distress.

However, not all children exposed to trauma develop symptoms with lasting impairment. Resilience is an individual’s ability to survive and adapt through adversity despite negative circumstances; it involves the complex interplay between individual characteristics and environmental factors. Moreover, resiliency traits are malleable, and child and adolescent psychiatrists can engage in efforts to strengthen the resilience of children exposed to trauma. Research suggests that neurobiological changes associated with trauma may be affected by intervention, and early inventions may more quickly and effectively shape neuropathways.

Trauma treatment for youth has grown in recognition and as an area of focus especially since the original ACE study was published in 1998. When treating trauma symptoms in children and adolescents, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one of the most empirically supported treatment modalities for trauma symptoms in youth. TF-CBT is validated for youth 3 years old up to 17 years old. The concepts of TF-CBT were initially developed for sexually abused children but TF-CBT has been validated for youth who have experienced other types of trauma, including natural disasters, physical abuse and war. In Jensen and colleagues 18-month follow-up study, the results supported the long-term effectiveness of TF-CBT for youth with diagnoses of PTSD as well as co-occurring depression compared to treatment as usual.

Other types of trauma-informed interventions for juvenile justice-involved youth are emerging. One such empirically-supported intervention is called Trauma Affect Regulation: Guide for Education and Therapy (TARGET). TARGET has three main components, including education about the neurobiological effects of PTSD, teaching self-regulation skills when trauma symptoms arise and an experiential exercise of the youth creating a timeline of his or her life. Marrow et al. found that the juvenile justice-involved youth who received the TARGET intervention had significantly lower rates of depression, anxiety, PTSD symptoms and an increase in perceptions of hope and optimism compared with treatment as usual.

For Julian, understanding his trauma history and mental health symptoms will help him, his providers, and the various involved care systems understand the origin of his challenges and how they have been adaptive in some certain circumstances and optimize a targeted treatment approach. In general, childhood trauma increases the risk for future victimization as well as perpetration of violence. Direct and indirect exposure to violence is associated with delinquency in youth and psychological problems, including depression, anxiety, substance use, and aggressive behavior. The association between trauma and delinquency is reciprocal—trauma increases the risk for delinquency and gang involvement and involvement in delinquent behavior increases the risk for additional traumatization and exposure to violence.

Julian reported obtaining a firearm for protection after witnessing his friend’s death by firearm. In one study on juvenile offenders, risk of gun carrying was significantly more likely after exposure to gun violence.

Cumulative trauma, chronic exposure to violence or stress, or polyvictimization increase a youth’s risk for poor health and social consequences. Therefore, addressing Julian’s trauma-related symptoms through appropriate evidence-based treatment is critical. However, focusing on treatment to target trauma-related symptoms runs the risk of overlooking an individual’s strengths and overall wellbeing, whereas the use of a strength-based approach to intervention has a basis within findings from the field of positive psychology. While trauma impacts people individually, we must remember that trauma is often experienced collectively, both within a whole family and often within a community, such as with Julian’s case. Thinking more broadly than individual treatment for Julian, models of collective healing and family-based treatment can be explored. Further, minimizing recurrent trauma exposure, stabilizing Julian’s current environment, and implementing
interventions that prevent revictimization are paramount to his recovery and to prevent recidivism.

**Take Home Summary**

Trauma is pervasive throughout the juvenile justice system. Studies show that children who experience trauma are at risk of poorer developmental and health outcomes. Clinicians should understand how justice-involved youth can be affected by a history of maltreatment. Interventions must focus on decriminalizing and treating trauma-related behaviors.

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This article was edited by J. Corey Williams, MD, MA.
The portrayal of suicide in popular music has been a topic of interest for some time. In 1984 there was notable controversy after 19-year-old John McCollum died by suicide while allegedly listening to the song “Suicide Solution” by Ozzy Osbourne. McCollum’s parents later filed a lawsuit against Osbourne claiming the lyrics incited their son to harm himself, though it was ultimately dismissed by the court. In fact, Osbourne claimed the song was intended to promote an anti-suicide message. In the mid to early 2000s, popular news outlets, including the Daily Mail, publicized the “dangers of emo,” a rock music genre characterized by its emphasis on emotional expression including suicidality and self-harm behavior.

Previous studies have investigated mental health themes in popular music, including substance use, relationships, personal identity, and suicide. Some imply that music reflects the circumstances under which it was created. Others report links between music content and subsequent observed behavior; one longitudinal study of 548 adolescents found associations between listening to music with aggressive or sexual content and aggressive or sexual behavior, respectively. Some evidence exists to support the idea that musical preference is an indicator, rather than a causal factor, of emotional vulnerability. A cross-sectional study conducted to investigate the relationship between adolescents’ music preference and their psychological health found significant associations between rock/heavy metal music and suicidal thinking and deliberate self-harm.

More recently, a content analysis of mental health references in 125 popular rap songs from 1998, 2003, 2008, 2013, and 2018 was performed and found the proportion of songs with suicidal ideation, depression, and mental health metaphors more than doubled over time. Notably, 6% of the 125 songs referenced suicide. In another analysis examining US top 40 songs from 1960-2010, references to suicide were found to be very rare, occurring in 0.6% of songs, and the authors found no trend in references over time. We performed a content analysis of suicidal references in US top 50 songs from the year-end Billboard Hot 100 between 2010 and 2019. Song lyrics were analyzed for the presence or absence of suicide reference. A song was considered to have a suicide reference if it included thoughts of wishing to be dead or direct mention of suicide or suicidal behavior. Two reviewers (PG + TD or PG + SG) independently examined each song, and any discordance in coding was discussed between the 2 reviewers to reach a consensus. Of all the songs examined, 1.7% of songs included a suicide reference, and three quarters of songs with a suicide reference fell under the rap/R&B/hip-hop genres. Songs with suicide references are presented in Table 1.

Discussion
The rise in popular rap songs with suicide references between 1998 to 2018 suggests there may be an increased openness to discussing suicide in this genre, which in 2018 was considered a favorite for the majority of 16- to 24-year-olds. Furthermore, several young popular artists in recent years have been increasingly outspoken about mental health issues and suicide. For example, during their acceptance speech at the 2020 Grammys, Billie Eilish’s songwriter/producer brother Finneas O’Connell stated they write about depression and suicidal thoughts, among other things, which may help destigmatize and normalize discussions of mental health. Artist Selena Gomez has openly discussed her personal experiences with mental illness and treatment, including dialectical behavior therapy, and in 2019 was granted the McLean Award for Mental Health Advocacy, making her the youngest recipient since
the award was established in 2008. Logic’s 2017 song “1-800-273-8255” is named directly after the former US National Suicide Prevention Hotline (Table 1), and the song’s release was associated with a 33% increase in phone calls to the Hotline and a 100% increase in Google searches of the Hotline compared to one year prior. Important, the widespread prevalence of social media and its popularity among young people likely helps propagate these messages. Selena Gomez, with over 265 million followers on Instagram, has used her platform to highlight her advocacy, which involves reducing the stigma associated with mental health and integrating mental health education into schools. Logic used Twitter to describe “1-800-273-8255,” explaining “I made this song for all of you who are in a dark place and can’t seem to find the light.” His tweets, in turn, were written about in magazines popular among youth, including Teen Vogue. While music has conveyed intense emotional states throughout time, it seems that mainstream songs and songwriters are increasingly more explicit and public in their relation to mental health themes.

Another important factor is that when an artist whose music depicts suicidal themes unexpectedly dies, their death may influence how listeners understand the meaning of their music. For example, Juice WRLD died of an accidental opioid overdose in December 2019, and XXXTENTACION was shot and killed in June 2018. A poignant article from The Guardian includes reactions from fans of several rap artists who have died, including Juice WRLD and XXXTENTACION. The fans, ages 20-27, each had unique experiences with the music, but common threads were the emotional connection to the artist, particularly when depression or addiction was depicted in their music, and grief with processing their deaths. Though none of these artists died by suicide, their deaths clearly affected young listeners. Based on the impact made on the public by artists who have died by suicide in the past, such as Kurt Cobain of Nirvana and Chester Bennington of Linkin Park, psychiatrists should consider having proactive discussions with young people when artists die suddenly, particularly if the patient has expressed admiration for the artist.

As mental health themes become increasingly familiar in popular culture, child and adolescent psychiatrists should feel comfortable discussing music with suicidal references in clinical practice. Notably, AACAP has published a guideline for families, “Listening to Music and Watching Music Videos,” which encourages parents to have open discussions about music with their children, with the stipulation to consider evaluation by a mental health specialist if there is a constant focus on music with destructive themes. We offer a few specific recommendations to help child and adolescent psychiatrists navigate using music with suicidal content in practice. First, we suggest asking youth and their

### Table 1. Songs With Suicide References

<table>
<thead>
<tr>
<th>Year</th>
<th>Number on The Billboard Hot 100</th>
<th>Song</th>
<th>Artist</th>
<th>Genre(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>25</td>
<td>Sail</td>
<td>AWOLNATION</td>
<td>Alternative/rock/Dance</td>
</tr>
<tr>
<td>2013</td>
<td>43</td>
<td>Same Love</td>
<td>Macklemore &amp; Ryan Lewis featuring Mary Lambert</td>
<td>Rap/R&amp;B/hip-hop</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
<td>Ride</td>
<td>Twenty One Pilots</td>
<td>Alternative/rock</td>
</tr>
<tr>
<td>2017</td>
<td>13</td>
<td>XO TOUR Lif3</td>
<td>Lil Uzi Vert</td>
<td>Rap/R&amp;B/hip-hop</td>
</tr>
<tr>
<td>2017</td>
<td>31</td>
<td>1-800-273-8255</td>
<td>Logic featuring Alessia Cara &amp; Khalid</td>
<td>Rap/R&amp;B/hip-hop</td>
</tr>
<tr>
<td>2018</td>
<td>17</td>
<td>Sad!</td>
<td>XXXTENTACION</td>
<td>Rap/R&amp;B/hip-hop</td>
</tr>
<tr>
<td>2018</td>
<td>12, 48</td>
<td>Lucid Dreams</td>
<td>Juice WRLD</td>
<td>Rap/R&amp;B/hip-hop</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td>Goodbyes</td>
<td>Post Malone featuring Young Thug</td>
<td>Rap/R&amp;B/hip-hop</td>
</tr>
</tbody>
</table>

Note: Lyrics with suicide references are presented here. “Lucid Dreams” was a top 50 song for both 2018 and 2019.
parents/guardians broadly about their music preferences and any perceived benefits of or concerns about the content of the music early in treatment, to facilitate the conversation about the potential role of music on a patient’s mental health. Second, as highlighted in AACAP’s guideline, we warn against pathologizing individuals based solely on their choice of music. Music depicting themes of depression, loneliness, and even suicide may be therapeutic for some individuals who otherwise may feel isolated.\textsuperscript{13} We suggest that psychiatrists take a curious stance and invite their patients to express their own interpretations of relevant songs, which may then be used to draw on themes related to larger treatment goals. The psychiatrist may consider asking questions such as “What do you think the artist means?” and “What stands out to you in this song?” We encourage providers to consider the larger perspective, wondering with their patients about their music preferences and making note of any meaningful changes over time. If a patient exhibits increased symptoms of mental illness correlated to increased listening of music with suicidal themes, we recommend first optimizing the patient’s safety and then addressing potentially relevant factors, such as music.

Finally, we suggest that child and adolescent psychiatrists remain aware of the major trends in popular music and artists, not because every young patient is interested in this genre, but because such trends can largely influence the greater culture. Calhoun and Gold have described how celebrities who self-disclose their own experiences with mental illness can positively impact public health.\textsuperscript{14} Child and adolescent psychiatrists should challenge themselves to approach music with suicide references with nuance, curiosity, and attention in their clinical encounters. In turn, they may learn insightful information about their patients and improve the therapeutic alliance.

**Take Home Summary**

While music has conveyed intense emotional states throughout time, it seems that mainstream songs and songwriters are increasingly more explicit and public in their relation to mental health themes, including suicidality. As themes about mental health become increasingly familiar in popular culture, child and adolescent psychiatrists should feel comfortable discussing music with suicidal references in clinical practice, particularly if artists die unexpectedly. Approaching such content with nuance, curiosity, and attention may help psychiatrists learn new insights about their patients and strengthen the therapeutic alliance.

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Connect Corner: Pixar’s Soul: Discussing Life and Death with Children

Liana Lau, MD, Megan Lin, DO, Steven Sust, MD

The acclaimed Pixar movie Soul boldly addresses existential questions about life, death, personality, and purpose. Delivered through a child-friendly medium, the film explores mature concepts that, for young audiences, may be their first acknowledgement of mortality. It may be daunting for parents to address their children’s questions of spirituality and death after the film. For parents who may be unsure about the concept of an afterlife, these issues may be particularly confusing to navigate. Drawing from child psychiatry perspectives, we hope to provide some initial age-appropriate guidance for these difficult questions.

THE GREAT BEYOND
Joe, the protagonist, is an aspiring musician whose life suddenly ends after landing a position in a coveted jazz band. After his life ends, he enters The Great Beyond, a place where souls await judgment.

Why Do We Die?
Joe’s sudden death in light of his imminent success can be very confusing to a young child, who may associate death with old age. Joe’s death can be a good opportunity for parents to attempt to see into their children’s inner world and explore their current conceptualization of life and death.

Children process death differently depending on their developmental stages. Toddlers (0-3 years old) have a more concrete, egocentric view of the world. For them, death or loss may be seen as a punishment. Preschool aged children (3-6 years old) may have difficulty understanding that death is irreversible, as they tend to create magical explanations rather than follow logical sequential reasoning. Elementary school aged children (7-11 years old) are capable of more abstract thinking and able to understand that death is permanent. Adolescents (12 years and up) have well established abstract thinking and are capable of a more sophisticated discussion.

Parents should tailor their conversations to their child’s developmental stage as their understanding of death varies. For younger children, it may be necessary to gently explain that death can be expected or sudden, but it is not a punishment for who we are or what we do. Because their thinking is more concrete, it would be helpful to avoid euphemisms that may confuse them further. Elementary school aged children would be able to start engaging in simple discussions of spirituality and religion. Adolescents are able to fully engage in discussions of death, though they are not likely to fully grasp their own mortality due to an inherent sense of invincibility commonly seen in adolescence. Regardless of age, reassurance that there will be a dependable loving presence in their lives is essential.

What Happens When We Die?
In the movie, Joe enters The Great Beyond. For young viewers who may not have had any discussions of death prior to watching the film, this concept may prompt them to innocently ask their parents about life after death. We encourage parents to research the child’s theories along with them. Depending on the child’s spiritual upbringing, this answer may be based in existing religious practices, or it can be an entirely new and mystifying concept. We encourage parents to maintain a non-judgmental, respectful approach and teach their children that there are many different faith systems which offer ideas about what happens after death. Examples include the parallel concepts of heaven and hell from Christianity, Sheol from Judaism, Jahannam and Jannah from Islam, and reincarnation from Hinduism and Buddhism. Providing exposure to various religious perspectives promotes the
child's own religious agency while also allowing for a better understanding of their peers' spiritualities.

THE GREAT BEFORE
The film depicts The Great Before as a place where new souls get their personalities, quirks, and interests before they go to earth.

Where Did I Come From?
Although this question can be answered literally by explaining biological conception, The Great Before introduces the idea that there may be a “life” before life on earth. Children may wonder if their personalities were developed before they were born, and whether some of their personality traits are fixed. We encourage parents to nurture a “growth mindset” as described by psychology researcher Carol Dweck. With the growth mindset, parents can teach their children that some intrinsic qualities can be changed through their own concerted efforts so that desired abilities can be developed. We suggest parents challenge the idea that we are born with rigid personality traits which cannot or will not change over time.

Do I Have a Soul?
In the film, Joe has a soul that remains constant before, during, and after life. Children may wonder if their souls continue to exist. The concept of having a soul varies among individuals. Depending on the religion, the soul may move on to a different body or a different form. The idea of a soul (with a personality, values, and likes/dislikes) as distinct from the body exists in many cultures. At the same time, it is acceptable to share that some questions, like this one, may not have an answer we can offer with absolute certainty.

EVERYTHING IN BETWEEN
Joe mentors a young soul on how to spark inspiration for life. He guides her to appreciate many aspects of life, from the most mundane to deeper ones, such as the importance of pursuing his life’s passion for music. Joe’s lifelong obsession with music and fame serves as a double-edged sword that not only drives his raison d’etre, but also blinds Joe to the other parts of his life that render balance and also make life worth living.

What is the Purpose of Life? If We Don’t Know What Happens After Death, Does What We Do Have any Meaning?
Young children are not likely to ask this question, but young and late adolescents may want to discuss this with their parents as they are navigating school and potential career choices. Joe’s purpose in life initially centers on his success in his career and then shifts to focus on relationships with others. In a psychological study comparing the views of theists and atheists regarding their views on what gives life meaning, both groups mentioned interpersonal relationships more than any other source of meaning. In child and adolescent psychiatry, we often promote personal wellness as a whole including physical, intellectual, social, emotional, financial, environmental, and spiritual aspects. Youth can be counseled that the wellness we strive for is actually a balance of these multiple factors. Instead of focusing on just one area, it is important for parents to encourage balanced living and foster personal wellness in many dimensions.

References

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This article was edited by Paula Wadell, MD.
More and more these days, it seems like youth are presenting for their initial psychiatry appointment already with a clear self-diagnosis in mind. I’m used to this for parents, who for years have hoped that I might rubber stamp their suspicions about bipolar disorder or ADHD, but this coming directly from kids is newer.

It’s come to the point where I often ask some direct questions about this early on, like “Is there a specific diagnosis you have been wondering about from your own research?” That’s usually followed up with a question of what, exactly, constitutes their “research.” Here, it’s common for my new patients to get a little sheepish when disclosing the source of their investigations, as most commonly the ideas come from social media platforms like YouTube or TikTok rather than things like the medical textbooks that used to make us doctors wonder about being stricken with lots of exotic ailments.

Some of these suspected psychiatric disorders seem to come in waves, corresponding to widely viewed posts that reverberate through social media communities. There has been the unexplained surge of youth presenting with tic disorders in the past, and more recently, what has appeared as a new epidemic of dissociative identity disorder (DID) following some viral videos on TikTok. Speculation has further arisen that social media has even been seen as contributing to increases in the prevalence of non-pathological things like describing one’s gender identity as non-binary or transgender or viewing one’s personality as an introvert.

The response to these youth when they divulge these new revelations about themselves has been quite mixed. While many might have expected a warm welcome to a generation that finally is “okay with not being okay” and won’t be constrained within rigid traditional norms, there’s actually been quite a bit of skepticism and even some scorn coming from unexpected directions.

To be fair, it can be tempting to greet someone’s new internet-inspired diagnosis with a full eye roll. Beyond that, though, there can also be real concern that youth putting on these labels as a “fad” can really undermine the progress that has been so hard earned to validate mental health conditions and an expanded view of gender identity. Consequently, it’s common to hear responses to these presentations that range from fully rebuking these youth as fakes to insisting that it is not really possible that peers or social media played much of a role at all.

And it’s here, where we dismiss or deny someone’s narrative right from the outset because it doesn’t fit our current scientific or political perspective, that we can start getting into trouble. Science, after all, has shown us over and over that virtually everything when it comes to human emotions, thoughts, and actions comes from a complicated mash up of mutually interacting genetic and environmental factors. These environmental contributors include things like peers and media influences, and their presence in the mix should not immediately disqualify someone’s history as underserving. Sure, it is much easier when trying to argue for the validity of something like major depressive disorder to use the example of the happy and healthy individual whose symptoms came on like a ton of bricks out of nowhere, but anyone who has spent time in this field knows that this path is just one of many.
One principle that has served me well over the years is the idea that the more complicated a clinical situation appears to be, the more important it is to stick to the basics. Establish a good rapport with the patient, ask difficult questions (particularly those elephants in the room ones that can be a little awkward), be thorough, validate while maintaining a bit of skepticism, and give yourself some time to conceptualize. In so doing, maybe in these supposed social contagion examples we find out that what seems like a new declaration of a dissociative disorder or gender dysphoria actually has been experienced and suppressed for years as the person waits for a more supportive environment. Maybe we find out that the particular internet-inspired diagnosis isn’t quite right but there is a lot of work to be done in another area. Or maybe we find out that, indeed, someone really has been heavily influenced by what they’ve heard from a peer or seen on a social media video as part of 1) developmentally appropriate needs to feel connected socially and 2) developmentally appropriate introspection at this age about their identity.

There’s no doubt that our world is increasingly polarized these days, pushing us to take a side. Real or fake. Right or wrong. Complexity, nuance, and middle ground has become equated with weakness and indecisiveness. But the reality, especially when it comes to the brain and its functions, is that things really are complex. Rigid and oversimplistic thinking often fail us and our patients by closing conversations that need to continue. The pathways through which our patients and clients find their way to our office are incredibly rich and diverse. We lump them into convenient boxes at our peril, virtually begging our patients to reveal to us the deficiencies of our mental shortcuts.

References

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David C. Rettew, MD, is Medical Director of Lane County Behavioral Health in Eugene, Oregon. He is author of the book Parenting Made Complicated: What Science Really Knows About the Biggest Debates of Early Childhood and the “ABCs of Child Psychiatry” blog on the Psychology Today website. You can follow him on Twitter at @PediPsych.

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