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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.

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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](http://www.jaacap.com/content/connect). AACAP members will receive emails announcing new quarterly issues.

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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.

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**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.
As I sat down to write this introduction, I began reflecting on AACAP’s 70th Annual Meeting held in New York City this past October. AACAP annual meetings have always been a mixture of euphoria and exhaustion for me. There are so many friends and colleagues to see, embrace, and check-in with, and not enough time; so much valuable educational content to consume, and not enough time; so many restaurants, social gatherings, and receptions to attend, but simply not enough time. When the flurry of the week ends and I return home to recharge, it is the sense of community and solidarity that endures. For me, solidarity with folks who are deeply concerned about the health and well-being of children and families cultivates an important source of hope. Especially in these trying times, it is important to seek out sources of hope and hold them close. I want to thank the AACAP community and readers of this journal for being a source of hope for myself and many others.

As we embark on another edition of JAACAP Connect, we continue our commitment to exploring innovative approaches and critical issues that shape the landscape of pediatric psychiatry. The articles in this edition not only reflect the diversity of challenges faced by children and adolescents but also underscore the constantly evolving nature of our field. Each contribution delves into distinct aspects of child mental health, offering fresh insights and strategies that hold the potential to enhance clinical practice, research, and policy. In the first article authored by Silai Mirzoy, “Parent-Child Interaction Therapy for Muslim-American Parents and Young Children” we explore the importance of culturally responsive interventions, understanding that effective mental health care must consider cultural nuances that resonate with diverse populations.

The second article, “The Implications of Loot Boxes and Their Involvement in the Possible Development of Childhood Gambling Disorders” Drs. Arlin Bhattcharjee and Gino Mortillaro delve into the intersection of gaming, technology, and child mental health. The authors examine the impact of loot boxes on the potential development of childhood gambling disorders, shedding light on a contemporary issue that demands attention. In the third article, “Pandemic Effects on the Perception of Eating Disorder X Posts Among Adolescents and Transitional Age Youth” by Chelsea Li et al., the authors examine how social media may have influenced the rise of eating disorders during the pandemic, especially for adolescents.

Turning our attention to the training of future practitioners, “Evidence-Based Practices: An Opportunity to Enhance Psychiatric Residency Training” author Rachel H. Olfson advocates for an increased emphasis on evidence-based practices, providing a roadmap for incorporating these practices into the training curriculum and discusses a specific treatment modality for complex patients. The fifth article, “Telepsychiatry and In-Person Care for Pediatric Patients During COVID-19: Patients’ Perspectives” by Sultana Jahan et al., investigates the experiences and perspectives of pediatric patients regarding telepsychiatry and in-person care during the COVID-19 pandemic. As the mental healthcare landscape continues to adapt to new challenges, this article contributes to our understanding of patient preferences and the impact of technology on the doctor-patient relationship.

We are thrilled to bring you this edition of Connect, and we hope this edition stimulates further reflection, discussion, and action, fostering advancements that ultimately benefit the mental well-being of children and adolescents.

J. Corey Williams, MD, MA
Editor
Parent-Child Interaction Therapy for Muslim-American Parents and Young Children

Silai Mirzoy, MD

There are limited data available regarding early childhood mental health in the Muslim American population. Nevertheless, the literature has shown that American Muslims are more likely to experience mental health disorders, including being twice as likely to report a history of suicide attempt compared to other religious communities. Despite these challenges, Muslims in America are often underserved and tend to underutilize mental health services, compared to other minority groups. The combination of Muslim children with significant mental health challenges and caregivers who underutilize mental health services reduces the likelihood that effective treatments will be used and increases risk of long-term harm for Muslim American children. Research has shown that Muslim American populations may be hesitant in seeking mental health treatment for a variety of reasons, including associated stigma behind mental illness within the community, fears related to past experiences of racism and discrimination in a post-9/11 world, differing way of conceptualizing mental illness and psychological distress that may lead to seeking alternative supports within family and community instead of mental health providers, and lack of knowledge about how to access formal mental health services. Another plausible reason for the underutilization of mental health services in this population is the concern that mental health treatment may not align with religious or cultural values.

The Muslim community in the United States is one that has vast diversity in terms of the ethnic, cultural, racial, and socioeconomic make-up of its groups, with a common thread binding them together of shared core values and principles rooted in Islam. It is important to note that these differences may be seen in the way that Muslims in the clinic present themselves (whether they choose to wear or not wear traditional outfits, hijab, kufis, beards) and how they decide to practice the religion. Assumptions should not be made that the information provided here is applicable to every Muslim who presents for treatment. However, the following discussion includes examples that are familiar to many individuals who identify as Muslim.

One effective way to provide support to the Muslim American population is to use evidence-based therapies that align with the religious values of Muslim Americans. For example, Parent-Child Interaction Therapy (PCIT), is a well-established, effective treatment in which there is an overlap in the skills that are stressed in PCIT and Islamic beliefs and attitudes towards parenting children. As an example, well-known advice given by Ali ibn Abi Talib, an important figure in Islamic history is: “Play with them for the first seven years of their life; then teach them for the next seven years; then advise them for the next seven years.” In Islam, one is guided by the teachings of the Quran and the Sunnah, or the traditions and practices, of the Prophet Muhammad, peace be upon him (PBUH). The evidence used to highlight why PCIT may be well-suited for Muslims derives primarily from the Sunnah.

Originally intended to treat disruptive behaviors in children ages 2 to 7, PCIT is an evidence-based intervention that is now used in the treatment of a wide range of emotional and behavioral difficulties in children across many cultures. PCIT originates from two theoretically distinct child therapy models: traditional play therapy and child behavior therapy. In traditional play therapy, the therapist follows and reflects the child’s behavior and emotions to convey acceptance and to allow for the child to express emotions safely. In child behavior therapy, the parent is seen as the agent of change based on the principles of attachment and social learning theory.
PCIT is a two-part intervention, child-directed interaction (CDI) in the initial phase followed by parent-directed interaction (PDI) in the second phase. Both phases of PCIT have overarching goals that align with basic goals that exist for parent-child relationships in Islam. CDI focuses on creating a warm, responsive caregiver-child relationship by introducing parents to a set of foundational skills that they use during play, designated by the acronym PRIDE. Children are dealt with through praise, the caregiver’s reflections of the child’s words and behaviors, imitation of the child’s play, description of their actions, and enthusiasm during the interaction with the child. PDI focuses on improving child compliance to parental instructions through behavioral management skills such as giving clear, effective instructions and enforcing predictable, structured time-outs for non-compliance.

Examples of the use of CDI PRIDE skills are quite commonly found within narrations from the time of the Prophet Muhammad (PBUH). As an example, a companion of Prophet Muhammad (PBUH) by the name of Jabir, said, “I came to the Prophet while Hasan and Husayn (Prophet Muhammad’s grandchildren) were on his back. The Prophet was walking on his hands and feet and saying, ‘You are having a good ride, and you are good riders!’” This interaction illustrates two major principles that are aligned with the foundational skills highlighted during the CDI component of PCIT, labeled praises and description of behaviors. It also shows the importance of sharing joy and connecting with children through enthusiastic play, by showing Prophet Muhammad (PBUH) participating in play as a way of connecting with his grandchildren.

Applying PRIDE skills involves allowing the child to lead the play by encouraging the caregiver to imitate the child’s behavior and reflect on what the child is saying. There are many accounts highlighting how Prophet Muhammad (PBUH) followed a child’s lead in play. For example, Prophet Muhammad (PBUH) was known to have a very noticeable birthmark on his back that Muslims refer to as the “Seal of the Prophethood.” One narration describes how Prophet Muhammad (PBUH) was holding a child who was playing with the seal that was between his shoulders and the father of the child became irritated. Prophet Muhammad (PBUH) indicated to the father to let the child be content in the play and allowed the child to continue what she was doing. He prayed for her to have a long life. By allowing for the child to take the lead, rather than disrupting the child’s play, Prophet Muhammad (PBUH) indicated that harmless play and curiosity about the environment and others is normal, expected, and should be encouraged.

There are many other instances that demonstrate how Prophet Muhammad (PBUH) highlighted the importance of child-directed play, including during tasks that are considered sacred by Muslims. Several accounts report on how he lengthened the congregational prayer when his grandson jumped on Prophet Muhammad’s (PBUH) back because he did not want to interrupt his grandson’s play. In another instance, Prophet Muhammad (PBUH) would shorten a congregational prayer if he heard a child in distress so the parent could attend to the child’s needs promptly. These are only a few of the examples of how CDI fundamentals overlap with the way that Muslims are instructed to care for their children within the parent-child relationship.

As mentioned previously, the goal of CDI is to help foster a warm relationship between the parent and the child through the mastery of PRIDE skills. While, on its own, this may be effective in helping to improve some behavioral difficulties that young children present with, PDI is conducted after CDI in order to help train parents on giving instructions effectively and safely disciplining their child in order to reduce problematic behaviors and increase compliance. Culturally, this will likely be attractive to Muslim parents because of the importance that is placed on children being respectful and compliant to the instructions of their parents.

PCIT is an evidence-based approach that can be used to support parents who are struggling with behavioral difficulties in young children. Through the development of warm relationships and the establishment of a safe, effective discipline method, the basic goals of PCIT
align with many of the goals of a healthy parent-child relationship within Islam.

This information can be applied within a clinical setting during the rapport building and initial phases of discussing treatment options. As always, clinicians should inquire about religion and spirituality prior to making assumptions based on appearance. Parents can then be explicitly asked if they have any specific concerns regarding treatment, including any related to the treatment’s alignment with religious values. If a family expresses hesitation as a result of these concerns, clinicians can offer the family additional information. Muslim clinicians who are treating Muslim patients could use these examples highlighted above to engage in conversations about the overlap between the goals for PCIT and principles for raising children in Islam. Clinicians who are not Muslim may offer to provide written information, in the form of the attached hand-out, to help provide additional information regarding this overlap.

All clinicians may find it useful to highlight the parts of PCIT that are in alignment with the values that are highlighted within Islam as summarized below.

- PCIT helps children 2 to 7 years of age learn how to listen to their parents and be obedient the first time that parents give them instructions to follow.
- PCIT helps children 2 to 7 years of age learn about the consequences of breaking rules in a safe, effective manner that can generalize to other environments outside of the home.
- PCIT helps children 2 to 7 years of age behave better in school as well so that they are able to learn without disruption to their education.

Through understanding and focusing on the overlap between Islamic values on parenting and the goals of PCIT, clinicians can enhance the therapeutic relationship, increase treatment retention, and improve buy-in of Muslim parents to use these skills in creating stronger, healthier relationships with their young children.

References
Take Home Summary

Muslim American populations may be hesitant in seeking mental health treatment for a variety of reasons, including concerns that mental health treatment may not align with religious or cultural values. Parent-Child interaction therapy (PCIT) could be effective in this population due to the overlap of its goals and Islamic beliefs and attitudes towards parenting. Through highlighting this overlap, clinicians can enhance the therapeutic relationship and increase comfort level of utilizing PCIT as a treatment modality.

About the Authors

Silai Mirzoy, MD completed her pediatrics, general psychiatry, and child psychiatry residency training and at the time of submission, was completing a fellowship in infant and early childhood psychiatry at Tulane University School of Medicine. She is an assistant professor of psychiatry at Tulane University School of Medicine and works as an inpatient child psychiatrist at the Children’s Hospital of New Orleans Behavioral Health Unit. She is particularly interested in providing trauma-informed care for young children and caregivers from immigrant and refugee backgrounds as well as supporting mental health in underserved and marginalized communities.

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The Implications of Loot Boxes and Their Involvement in the Possible Development of Childhood Gambling Disorders

Arlin Bhattacharjee, MD, Gino Mortillaro, MD

“I refuse to promote the gacha system in this game anymore.” This was a comment made by a 13-year-old YouTuber named Michael “@mtashed” Tash with over 600,000 followers. Many of his followers are children who were likely drawn to his entertaining commentary on popular games such as Destiny, Dark Souls, and Genshin Impact. While the concept of a “gacha game” is likely unfamiliar to many clinicians, this phenomenon has significant relevance to child and adolescent psychiatry.

As of January 31, 2021, according to appfigures.com—a website that measures app usage among other metrics—the top 30 grossing apps on mobile operating system iOS mostly consisted of dating, streaming, and video game apps. Within those apps, Genshin Impact ranked 26 and Raid Shadow Legends ranked 25. Despite not being ranked in the top 5, these games still made a relatively substantial gross income. Games such as these are “free” to play, but according to Sensor Tower, a mobile analytics firm, Genshin Impact makes more than 6 million dollars per day from the mobile version alone, which does not include income generated from those playing on consoles or computers. Comparatively, an individual casino makes on average around $630,000 USD per day according to businessinsider.com. So, how does a “free” game make 10 times the earnings of a single casino?

Loot Box or Childhood Gambling?

In 1958, a study on intermittent reinforcement in children aged 4 to 8 was done by Long et al., which found that variable ratio schedules, compared to fixed and variable interval schedules, produced the most effective reinforcement behaviors. The study had 200 children work by operating a particular device and would reward them with certain reinforcers. It was noted that the “reinforcers,” particularly the trinkets which were used, would lose their reinforcing effects if they lost their variation such as when the child had already received each trinket. However, introducing new trinkets revived the reinforcing effect. This study also noted that these effects found in children, translated over to animals, indicating that studies on reinforcement performed with animals, may be relatively applicable for children.

The variable ratio reward mechanism is when an average number of actions returns a reward. This average can be 3 or a thousand, but regardless, the subject may receive the reward either on the first action or on the sixth action in either case, with the likelihood of that occurring higher in the first scenario notwithstanding. Previous research completed in the 1950s by B.F. Skinner, first showed this...
The randomness of rewards appears to make humans and animals consistently complete actions that bring about these rewards. This research supports that notion of the powerful effects of variable ratio reinforcement on childhood behaviors, raising concerns around the potential impacts of video games, particularly ones that utilize loot boxes (that appear to mirror a variable ratio reinforcement strategy).

In a study comparing 222 adult pathological gamblers and 714 controls, who did not have other addictive behaviors (including substance abuse), it was found that 50.9% of those with a gambling disorder had the Taq A1 variant of the DRD2 gene whereas 25.9% of the controls had the same variant. This study suggests that the dopamine receptor, specifically the Taq A1 variant, is linked to gambling disorders. Another study by Linnet et al. showed that individuals who were diagnosed as pathological gamblers, appeared to have a significantly increased excitement level in correlation to dopamine release in the ventral striatum when compared to controls, suggesting that the severity of the gambling behaviors may be associated with the intensity of this dopaminergic response. As such, dopamine is released upon reward, and that rewards at random rate can solidify gambling behaviors.

Many of the core features of loot boxes have similarities to gambling. For example, when a player opens a loot box, they may receive random items of varying worth up to $100,000 USD. These items range from being purely aesthetic to those that may help players complete games more easily. Especially for a young child whose social life may revolve around time being spent on online games, this may all be appealing, and there may be a surge of dopamine that occurs when a random reward is received. In turn, this may encourage the child to continue opening an increasing amount of loot boxes in the hopes of receiving that single $100,000 item, or an item that helps them complete the game; thereby, increasing the child’s risk of developing a gambling disorder.

Five main components for gambling disorder exist within the DSM V-TR: a preoccupation with gambling, the desire to use more money for more excitement, the inability to cut back or stop behaviors, restlessness or irritability when attempting to cut back, and using gambling as an escape such as to minimize a depressed mood. Based on their design, gacha games may increase a child’s proclivity to anyone, if not all these symptoms.

The increased use of internet games comes with many risks, especially for minors, and potential areas for future inquiry. Moving forward, it may be wise to investigate what exactly these risks are and how they interact with one another. Are these games a gateway to developing addictive behaviors or gambling disorders? The gaming and scientific communities have begun looking at these associations and have begun to show increased risk. With this increased risk, can a child develop such disorders at a young age? If so, how can a clinician assess and identify such behaviors or disorders? Finally, if these game designs truly have a negative impact on a child’s development should there be legal regulations around such games that implement loot boxes?

**Relevance in a Post-COVID World**

Since COVID 19, youth appear to be spending an increasing amount of time engaged in digital media and online activities, especially internet gaming, and the emergence of virtual reality games may compound this trend. About 16 hours a day is being spent on digital media by the average adult, compared to the pre-pandemic 12 hours a day, and if these trends are paralleled in children, this does not bode well, especially for those children who may have a developmental vulnerability to addictive behaviors. Childhood vulnerability to addictive behaviors may be exploited by video games that promote gambling behavior like gacha games. Therefore, it is important to understand the significance and impact of such issues moving forward, as early identification and intervention may help minimize gambling addictions throughout the lifespan.
References


Take Home Summary

Mechanics implemented in modern day gaming systems may pose a risk for the development of addictive behaviors. It may be warranted for providers to monitor and potentially screen for such behaviors, particularly in a behaviorally susceptible population such as children and adolescents.

About the Authors

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This article was edited by Adam Sagot, DO.
Eating disorders (EDs) are serious mental health conditions that can have devastating physical and psychological effects. They are significantly underdiagnosed and undertreated, and many individuals suffer in silence due to stigma, shame, and lack of access to appropriate care. Adolescents and transitional age youth (TAY) suffer from high prevalence of EDs, highlighting the need for effective prevention and intervention strategies, and improved access to evidence-based treatment options. Estimates suggest that at least 9% of the global population suffers from EDs, with the average age of onset being 18 years. Adolescents aged 13 to 18 are particularly vulnerable, with approximately 2.7% affected. TAY likely have an even higher number of ED cases. EDs have the highest fatality rates of any mental illness, with an estimated 4% of patients with anorexic nervosa dying from complications.

The growing use of social media among these age groups highlights its potential as a research tool to observe trends in the prevalence and severity of EDs in response to world events. Additionally, various studies link social media use to higher levels of body dissatisfaction, disordered eating, and negative self-image, making it a powerful influence on the development and maintenance of EDs. The use of social media platforms such as X (formerly known as Twitter), Instagram, TikTok, and Snapchat exposes young people to curated images and messages that promote unrealistic beauty standards and stigmatize larger body sizes. These messages can trigger or exacerbate eating disorder symptoms in vulnerable individuals, fueling a cycle of negative thoughts and behaviors that can be difficult to break.

The COVID-19 pandemic further complicated the relationship between social media and EDs. Individuals turning to social media platforms as a source of connection and entertainment during lockdowns and quarantines contributed to an increased risk of exposure to disordered eating content. Social media can provide a sense of community and support for individuals struggling with EDs but can also reinforce maladaptive thoughts and behaviors by creating echo chambers of disordered eating and by encouraging maladaptive comparisons to others’ appearances and lifestyles.

The increased use of social media has made adolescents and TAY more vulnerable to developing EDs, particularly during the COVID-19 pandemic, when people reported worsening mental health due to isolation and excessive social media usage. Our goal was to understand how the COVID-19 pandemic affected engagement with EDs by analyzing X (formerly known as Twitter) trends. We hypothesized that we would see an increase in messages with content related to EDs after the onset of the pandemic.

Method

We utilized public data from X (formerly known as Twitter) API, yielding 476,375 posts (formerly known as Tweets) related to EDs collected from January 1, 2019, to late January 2022. Posts were selected for and restricted to topics related to EDs using the following hashtags: “#anorexia,” “#anaprobs,” “#bulimia,” “#bingeeatingdisorder,” “#compulsiveeating,” “#ednos,” “#edprobs,” “#proana,” “#promia,” “#thinspo,” “#thinspiration,” “#bodyslip,” “#edtwt,” “#bodycheck,” and other similar hashtags that have been used in previous research on the topic. Many of the keywords are related to the DSM-IV criteria for clinical diagnosis of ED. We limited promotional content by excluding posts with keywords such as “promo code,” “% off,” “use the code,” and “check us out.”
We performed sentiment analysis on all posts using the Valence Aware Dictionary and sentiment Reasoner (VADER) tool, with scores averaged per week. The VADER tool computes a normalized, weighted composite score for each post, with -1 representing most extreme negative sentiment and +1 representing most extreme positive sentiment. We compared means using two sample t-test on the averages of the number of ED-related posts per week and the average sentiment per week between the “pre-COVID” (Jan 2019 – Feb 2020) and “post-COVID” (March 2020-January 2022) time periods. We split pre-COVID and post-COVID time periods on March 11, 2020, when the World Health Organization declared COVID-19 a pandemic.

To supplement the sentiment analysis, we performed a qualitative analysis of a random sample of 500 ED-related posts, 250 each from before and after pandemic onset. Coders manually categorized posts into several categories, including “pro-EDs,” “against EDs,” “in recovery,” “research,” “discussion,” and “ads.” Inter-coder reliability was assessed with a portion of the sample dataset. Coders also took note of any overarching themes found in the “pro-EDs” posts, which were defined as posts that promoted unhealthy eating or exercise behavior. We used Z-score tests for two population proportions to determine significant differences in the proportion of the different categories of posts between pre- and post-COVID time periods.

We used custom Python code to quantify and collect posts relating to EDs, to conduct the sentiment analysis, to perform all statistical tests, and to generate Figure 1.

**Figure 1. Weekly Post Number and Average Sentiment**

**(A)** Weekly Post Number

**(B)** Average Weekly Sentiment

**Note:** (A) Total number of posts per week from January 2019 to January 2022. The blue line represents the start of the pandemic declared by the World Health Organization. (B) Average sentiment of all posts from each week from January 2019 to January 2022. The blue line represents the start of the pandemic declared by the World Health Organization.
Results

Of the 476,375 posts collected, the top ten key hashtags among all ED-related posts were “#ed,” “#anorexia,” “#bulimia,” “#proana,” “#proanatwt,” “#thinspo,” “#thinspo,” “#edtwt,” “#ana,” and “#meanspo.” The average number of posts under each hashtag was 53,378, with “#edtwt” having the greatest number of posts at 248,016.

When looking at the average number of posts per week, we observed a significant increase in the number of weekly posts relating to EDs, from 1,292 (SD= 282) posts per week pre-COVID to 4,072 (SD= 953) per week post-COVID (t(48) = -26.954 , p < 0.001) (Figure 1A). Average weekly sentiment regarding EDs increased from 0.053 (SD= 0.039) to 0.116 (SD = 0.042) after March 2020 (t(48) = -9.55, p < 0.001) (Figure 1B).

Accordingly, we found an increase in the percentage of favorable, “pro-ED” posts, from 49% pre-COVID to 73% post-COVID (z = -5.6795, p < 0.00001) in our manually coded sample of 500 posts. Some of the themes that we noticed included a greater sense of “community” in post-COVID pro-ED posts, with more requests for “mutuals” (X [formerly known as Twitter] users who reciprocally follow each other), polls, advice, and sharing of experiences with different diets and foods. Reflecting the greater percentage of “pro-ED” posts in the online X (formerly known as Twitter) community, the proportion of all other ED related posts dropped pre-COVID to post-COVID. The number of posts explicitly discouraging ED behaviors dropped from 4% pre-COVID to 3% post-COVID (z = 1.2338, p = 0.2187). The number of posts where users shared about their experiences in ED recovery dropped from 11% pre-COVID to 3% post-COVID (z = 3.4602, p <0.001). The proportion of all other posts (in other categories such as research, discussion, and ads) dropped from 32% pre-COVID to 21% post-COVID (z = 2.6378, p < 0.01).

Discussion

In summary, our study found that the number of ED-related posts increased after the COVID-19 pandemic onset and its associated government-mandated lockdowns. These findings reflect the rise in mental health concerns among people during the pandemic. Specifically, we noted an increase in the proportion of posts expressing positive sentiment towards EDs, which coincided with clinicians’ reports of a surge in hospitalizations related to EDs during the pandemic. The increase in positive sentiment towards EDs may reflect a coping mechanism among individuals who were struggling with the pandemic’s effects on their mental health.

Our study underscores the need to preempt mental health exacerbations, especially among adolescents and TAY, during global events that cause undue stress and isolation. Future pandemics and environmental changes due to global warming are prime examples of such events. Caregivers, parents, teachers, and physicians should work together to develop strategies to mitigate the negative effects of such events on the mental health of young individuals.

Furthermore, we found that the content of the posts seemed to promote community, raising questions about the role of social media as an echo chamber for individuals with EDs. While social media can provide a sense of community to people with EDs who may feel isolated and alone, it may also exacerbate their conditions if it promotes unhealthy behaviors. The glorification of certain EDs on social media may result in individuals with these disorders feeling validated and may lead to increased engagement with these behaviors.

Our study, along with others, highlights the need for further investigation into the benefits and harms of social media in the context of mental health. For example, we should consider whether patients should have access to the internet during inpatient unit stays, or whether their access should be limited to mitigate the potential negative effects of social media on their mental health. Additionally, we should explore whether parents should limit their children’s social media exposure, and if so, how to implement such limitations effectively. These are important questions that require further investigation to ensure that individuals with EDs receive the support they need to maintain their mental health in a world where social media plays an increasingly significant role.
References

Take Home Summary
We found that on X (formerly known as Twitter), both the number of posts relating to EDs and the proportion of those posts promoting negative ED behaviors significantly increased during the COVID-19 pandemic, possibly due to isolation and increased use of social media among adolescents and transitional-age youth.

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This article was edited by Andrés Martin, MD, PhD.
I received the AACAP Junior Investigator award during my second year of fellowship and completed it during my first year on faculty—so it truly accompanied me through a time of intense transition and professional growth. Through this award, I was able to receive one-on-one mentorship from Jeanne Miranda, PhD, a renowned health services researcher, just prior to her retirement. I learned how to plan and organize a basic psychotherapeutic research project, including the less-glamorous components of research (i.e., budgets and IRBs). This project funding ultimately led to the creation of an AACAP SPOTLIGHT

Natalie Ramos, MD, MPH

2016 AACAP EDUCATIONAL OUTREACH PROGRAM (EOP)
FOR CHILD AND ADOLESCENT PSYCHIATRY RESIDENTS
SUPPORTED BY AACAP'S LIFE MEMBERS FUND

2021 AACAP PHYSICIAN SCIENTIST PROGRAM IN SUBSTANCE USE K12 CAREER DEVELOPMENT AWARD, SUPPORTED BY NIDA

Project Title: Family-Focused Therapy for Transgender and Gender Diverse Youth at Risk of Substance Use and Co-occurring Mood Disorders (FFT-TGD)
The AACAP K12 Award has truly impacted my career trajectory and interests, providing experiential training on mixed methods research methodology, NIH-funded grant management, and substance use early intervention for adolescents. The AACAP team has made this daunting project manageable and enjoyable, and I have been exposed to incredible research mentorship from both the Academy and my own institution. I am so fortunate to receive mentorship on this project from David Miklowitz, PhD, and from an incredible panel of AACAP research mentors, including Catherine Martin, MD. Lastly, the protected time has fostered a renewed interest in learning and substance use training—believe it or not, I even took a full statistics class last year!

2017 JUNIOR INVESTIGATOR AWARD, SUPPORTED BY AACAP, PFIZER INC., SUNOVION PHARMACEUTICALS INC., AND SUPERNUS PHARMACEUTICALS, INC.

Project Title: Building Resilience in Gender and Sexual Minority Youth: A Skills-Based Group Intervention to Improve Mental Health
I received the AACAP Junior Investigator award during my second year of fellowship and completed it during my first year on faculty—so it truly accompanied me through a time of intense transition and professional growth. Through this award, I was able to receive one-on-one mentorship from Jeanne Miranda, PhD, a renowned health services researcher, just prior to her retirement. I learned how to plan and organize a basic psychotherapeutic research project, including the less-glamorous components of research (i.e., budgets and IRBs). This project funding ultimately led to the creation of an ongoing CBT-based skills group for depressed LGBTQ teenagers, which is still running at UCLA and with partners across California. I presented posters at the 2019 AACAP Annual Meeting and at WPATH 2018 in Buenos Aires and gained experience in writing a paper on a mixed methods intervention adaptation study.

AACAP COMMITTEE WORK
I am currently serving in my fourth year as co-chair of the Sexual Orientation and Gender Identity Committee (SOGIC), a position I feel honored to hold. I have benefited immensely from mentorship from former co-chairs, Scott Leibowitz, MD, and Sally Herbert, MD, who taught me the ropes of Academy leadership in a formative stage. I would also be remiss not to mention Mark DeAntonio, MD, who accompanied me to my first committee meeting as a wide-eyed first-year fellow and told me to go for it, no matter how daunting it seemed. With LGBTQ youth currently under attack from legislatures across the country, SOGIC has become ever more important as a resource for evidenced care protocols, education, and advocacy.

MENTORSHIP
I have benefited tremendously from the mentorship I have received early in my career. “Pay it forward” is a motto I try to keep at the forefront even during busy times. Within AACAP, I serve as a mentor to trainee members on SOGIC and trainees seeking exposure to LGBTQ-focused education, writing, and advocacy. I have a wonderful Research Assistant on my K12 project team whose post-college career I am excitedly following. At my own institution, I provide clinical and research exposure to LGBTQ medical students and medical students of color interested in youth mental health and/or LGBTQ-affirming care.

MILESTONES
It is no exaggeration to say that the research awards and mentorship I have received through AACAP have made a profound impact on my career trajectory. My close involvement in SOGIC also aligns with my personal values as a queer woman who works with LGBTQ youth daily. My connection to peers and colleagues through AACAP continues to be a source of inspiration and camaraderie during this unprecedented time of anti-LGBTQ sociopolitical attacks.
Evidence-Based Practices: An Opportunity to Enhance Psychiatric Residency Training

Rachel H. Olfson, MD

Starting back at me through the Zoom interface was a small, thin-faced boy, too nervous and overwhelmed to tell me anything more than his own name and the name of his dog: Cooper. This was the first child therapy case I was assigned as a resident trainee. He was a young adolescent with acute lymphoblastic leukemia. Two years ago, he was outgoing, playful, and sociable. Now he apprehensively stared at me, underweight and highly anxious. He was experiencing medical trauma through countless hospital admissions for chemotherapy and opportunistic infections during the ongoing global pandemic. At the time he was transferred to my care, he carried multiple psychiatric diagnoses, including generalized anxiety disorder, major depressive disorder, and posttraumatic stress disorder. I had no idea where to begin. Though I was in my third year of Triple Board training, which includes adult psychiatry, pediatrics, and child psychiatry fellowship, I felt unprepared. My education and exposure to psychotherapy had been somewhat limited; but even still, I knew that learning effective, evidence-based therapeutic skills would not be straightforward.

This early experience led to some reflections on the role of psychotherapy education in psychiatric residency training, and the divergent views on this topic. Some educators feel that psychotherapy is an integral part of the origins and practice of psychiatry; it distinguishes psychiatry from other fields of medicine. While others view contemporary psychiatry as rooted in the neurological understanding of mental disorders as well as expertise in the management of psychopharmacology. Through this lens, psychotherapy may be seen as the domain of other practitioners on the mental health team, such as psychologists and social workers. Nonetheless, psychotherapy is considered a core competency for psychiatrists and an essential treatment modality in the field of practicing child and adolescent psychiatry according to the American Academy of Child and Adolescent Psychiatry (AACAP).

As a psychiatric resident there is a sense of pressure in the time-limited nature of training. There is an emphasis on the importance of mandatory clinical rotations, which are key to clinical practice. Though there are opportunities for longitudinal care of patients, exposure to and instruction around well-researched psychotherapeutic tools, such as evidenced-based practices (EBPs) are limited. In the final year of my training, reflecting on these experiences sparked my interest in learning more about EBPs and how they might be integrated into residency training programs.

EBPs apply empirically supported principles of assessment, intervention, and care. They are typically delivered in a structured or semi-structured approach. Over the past 50 years, a variety of EBPs have been developed through rigorous research for youths struggling with an array of mental and behavioral health challenges, and there is evidence that EBPs outperform usual care.

The demand for child mental health care has become increasingly emergent during the COVID-19 pandemic. In October of 2021, a national emergency in child and adolescent mental health was jointly declared by the American Academy of Pediatrics (AAP), AACAP, and the Children’s Hospital Association (CHA). This included advocacy for increased governmental funding for access to “evidence-based mental health screening, diagnosis, and treatment.” Thus, there exists a timely opportunity to invest in the integration of EBPs into the education of psychiatric trainees.

A critique of EBPs is that they have not been extensively implemented or studied among ethnically diverse populations.
Evidence-Based Practices: An Opportunity to Enhance Psychiatric Residency Training

populations; moreover, there exist disparities in access to quality mental health services for racial/ethnic minority children compared to White peers.\(^6\) Nonetheless, there is some evidence that EBPs are effective and generalizable among a diverse population of children. In a retrospective, multi-year cohort study in youths across 25 community-based outpatient mental health clinics, it was found that EBPs were generally associated with similar improvements across racial/ethnic groups. As assessed by caregiver report scales, Hispanic youths tended to benefit more from EBPs than treatment without EBPs, and they had similar outcomes to non-Hispanic, White youths.\(^7\)

I was reminded of my complex oncologic patient when I later learned about the Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress or Conduct Problems (MATCH-ADTC).\(^8\) The MATCH program integrates components of widely used EBPs for anxiety, depression, trauma, and conduct problems. Though I did not have the training at the time to employ such tools in his treatment, it led to an interest in learning more about how such a therapeutic modality might be integrated into psychiatric training.

The MATCH program uses a modular approach, as opposed to the standard manual-based approach, and integrates components broadly used in EBPs. As MATCH was designed to combine common, evidence-based elements of treatment for multiple diagnoses, it circumvents the extensive time and monetary investment that would be needed to train providers in multiple EBPs. Thus, it allows the provider to not only treat patients with overlapping diagnoses, but also affords opportunities to address fluctuations in presenting symptoms that may emerge during treatment.

MATCH is efficient. It has been shown to provide youth and families with a quicker rate of improvement, in a shorter duration of care, as well as greater reduction in number of problem areas compared to usual care.\(^9\) It has lasting effects. Research supports that the improvements that resulted from the MATCH modality, compared to usual care, are still present after two years.\(^10\) Furthermore, while the program was designed and tested on children aged 6-15, aspects may be adapted for youth up to age 17.\(^8\) In addition, there is evidence that children treated with MATCH compared to standard care were less likely to be additionally treated with a variety of psychotropic medications.\(^11\)

Though there are a variety of barriers that exist to integrating the use of such an EBP into psychiatric residency training, a pilot study has shown that such training is not only possible, but also in line with Practice-Based Learning and Improvement (PBLI), competencies required by Accreditation Council for Graduate Medical Education (ACGME). This pilot involved 12 child psychiatry trainees receiving training, supervision, and delivering Managing and Adapting Practice (MAP), which is similar to MATCH, in a year-long outpatient teaching clinic.\(^12\)

Preliminary findings supported that trainee use of MAP provided useful tools and structures that addressed the core components of PBLI in child psychiatry training. Nonetheless, even in a pilot form, there existed a notable investment in time and resources, such as 5 full days of fellow training, existing experienced supervisors, and further trainee protected time and resources in ongoing support of implementing MAP.

Patients such as my first child therapy case continue to teach me that the practice of psychiatry, and particularly psychotherapeutic techniques, are an exercise in lifelong learning. Though it is not clear exactly how EBPs can be effectively integrated into psychiatric training programs, it is worth considering how impactful such an investment could be. With a national shortage of mental health providers, each trained child and adolescent psychiatrist represents an opportunity to help multiple children, not just as a direct provider, but also as a mental health team leader. Even though many child psychiatrists may not go on to regularly practice psychotherapy, it is important that their training provides them with tools to understand, support and collaborate with practitioners who use evidence-based practices, especially in a time of such growing need for child mental health care.
References


Take Home Summary

Evidence-based practices (EBPs) represent therapeutic approaches that apply empirically supported principles of assessment, intervention, and care for youths. Though a variety of barriers exist, there are also notable potential benefits of integrating EBPs into child and adolescent psychiatric training programs.

About the Authors

Rachel Olfson, MD, is a child and adolescent psychiatrist with Bradley Hospital’s outpatient services team and the Intensive Program for Obsessive Compulsive Disorder and Related Disorders. She is a clinical instructor in Brown University’s Department of Psychiatry and Human Behavior. She completed training through the Triple Board Program at Tufts Medical Center in Boston, MA, and served as chief resident during her final year.

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The COVID-19 pandemic has changed how child and adolescent psychiatry’s practice. Nationwide restrictions and public health recommendations have reshaped the patient care setting to avoid spread of the virus. A major shift came in the form of telehealth, which allowed patients to attend clinic appointments online. Some of our clinic’s child and adolescent psychiatrists began practicing telehealth in March 2020 and continued completely virtually for one year. Other providers in our practice continued with in-person visits.

Objective
The objectives of this study were to identify advantages and disadvantages of the telehealth delivery system and to devise future strategies for improving patient and caregiver satisfaction. The study hypothesis was that more people would prefer telehealth visits compared to in-person visits. Because telehealth visits allowed psychiatric care to continue when all nonessential operations were shut down. All patients surveyed had some experience with the telehealth format during this phase of the pandemic. Patient feedback, as reviewed in this study, may be used to improve telehealth services, and determine how telehealth will be incorporated into the landscape of post-COVID-19 clinical services.

Method
A proposal was approved by the University of Missouri-Columbia Internal Review Board to conduct this study. One hundred patients were randomly selected to be given study questionnaires. This study conducted comparative survey research with 50 patients seen primarily virtually and 50 patients primarily seen in-person. The patient pool was drawn from Columbia, Missouri as well as smaller surrounding communities. Identical survey questions were filled out by all patients and their respective guardians. The survey’s first question asked which setting was preferred during the COVID-19 crisis and was followed by free response questions prompting responses about what each liked and disliked about telehealth and in-person visits. This free response format allowed multiple answer responses and enabled participants to fill out all 5 survey questions or leave some blank.

Figure 1. Patient Preference in Telehealth vs In-Person Visits
Results
Of the 50 patients seen virtually, 72% indicated a preference for telehealth, 14% preferred in-person, and 14% had no preference (Figure 1). These patients who preferred telehealth reported it was convenient, required no travel, and required fewer absences from school or work (Figure 2). Twenty-eight percent of patients listed safety from exposure to COVID-19 as a reason they liked telehealth. Some patients also expressed they were more comfortable with telehealth than in-person appointments because they could be in their own home or another familiar environment during their appointment. While over half of the virtual visit patients reported no complaints with telehealth, the most common reported issue was internet connectivity and technology problems (Figure 3).

The second most common complaint regarding telehealth and the highest reported advantage of in-person visits involved the element of personal connection (Figure 3-4). In addition to personal connection, there was some concern with the more physical aspects of psychiatric care. Sixteen percent of patients seen virtually and 24% of patients seen in-person reported more accurate assessment as an advantage of in-person care (Figure 4). The patients listed concerns about body language, vital signs, and other physical symptoms that may impact accuracy of assessment.

The 50 patients seen in-person differed in their responses from the 50 patients seen virtually. Sixty-four percent of in-person patients reported a preference for in-person visits during the COVID-19 crisis (Figure 1). Similar to virtual patients, convenience was the most popular...
advantage of telehealth, and personal connection was the most common disadvantage (Figure 2, Figure 3). While more than 50% of patients seen in-person reported no disadvantages to in-person care, patients seen via telehealth listed potential exposure to COVID-19, the need to travel, and scheduling difficulties (Figure 5).

Discussion

This study suggests that there was a range of preferences and reservations for patients receiving both in-person and telehealth care. The second most common complaint regarding telehealth was the element of personal connection. Patients desire in-person reciprocity and the ability to read body language, and some indicated this was not consistently possible in telehealth appointments. It appears that children and adults alike are craving human interaction after the sudden and all-encompassing shift from in-person to virtual. With school, work, extracurricular, and social events moved online, the desire for a face-to-face appointment is understandable. Other reported concerns were about body language and vital signs. Body language not only may be a physical symptom of a mental illness, but it is also important for building a personal relationship. Vital signs, though not a part of every outpatient psychiatry visit, may be necessary for monitoring certain psychotropic medications.

For some patients seen in-person during the pandemic, the positive impact that personal connection had on psychiatric care outweighed their concern with COVID-19 exposure. The comfort of talking face to face and not having to worry about technology outweighed concerns with travel and scheduling.

While several patients preferred telehealth, in an age of digital divide, we observed that stable internet access was not a reality experienced by all, and rural areas struggled the most. Even with access to a reliable device and stable internet connection, some people still struggled with navigating their patient portals and the audio-visual platforms used for telehealth appointments.1,2 With the sudden shift to online operations, technological and digital literacy was put to the test during the pandemic. System-specific patient education and platforms that are easily accessible to vulnerable populations are needed to improve technological and digital health literacy.

In the state of Missouri alone, during the pandemic, it was estimated that 780,000 residents did not have access to the wired broadband connection needed for what is considered high-speed internet.3 Furthermore, 350,000 residents do not have access to any speed of broadband.4 To address this, Missouri allotted $20 million of the state’s Coronavirus relief fund to expand broadband connectivity, as reported by the Missouri Department of Economic Development in July of 2020.4 Another $5.25 million was used to support telehealth connectivity and provide hotspots for federally qualified health centers in Missouri.4 Patient internet access was also supported by federal initiatives including the Emergency Broadband Benefit Program, which was replaced by the Affordable Connectivity Program in November 2021.1 Investment in internet accessibility helped our clinic’s patients to continue receiving care via telehealth when they could not come for in-person visits.

Conclusion

A recently published article in Psychiatric News reported “APA president Jeffrey Geller, MD expects psychiatric practice to be a hybrid model that uses video, telephone, and in-person visits as appropriate.”5 He continued, “My hope is that this hybrid practice will be designed to meet individual needs and driven by patient preference rather than driven by finding.”6 Telehealth is becoming all but ubiquitous in the medical field. With telehealth as a seemingly permanent aspect of medicine, the field of psychiatry must adapt. Problems within the delivery of telehealth may not be addressed unless we understand their existence. In reviewing survey responses, common themes emerged that may be used to improve telepsychiatry. Expansion of broadband and increasing affordability of high-speed internet connection are practical solutions to technological issues with telehealth. Implementation of virtual platforms requires both provider and patient understanding; to prevent barriers to care, training and technical assistance must be available.6 In the interest of personal connection, providers should
use patient names and communicate as they would in the office. For patients preferring to be seen virtually, a recommendation can be made to have at least the first visit in-person to establish a personal relationship. A pre-established trusting relationship built in-person would likely ease the shift to virtual care. For patients that need vital signs, it may be an option to purchase the equipment and take vitals at home after training in the clinic. These vital signs could then be reported to their provider during telehealth visits. Some barriers presented by psychiatric telehealth are more difficult to address than others, but consciously implementing these suggestions may increase patient satisfaction.

According to the article published in *Psychiatric News* in May 2021, “for psychiatrists who practice psychopharmacology, telepsychiatry is likely to continue to be prominent.”

To that end we must remain vigilant and develop better strategies to improve the quality of patient care and patients’ satisfaction.

**References**


**Take Home Summary**

Telehealth has become an integral part of our daily practices, especially since COVID-19 pandemic. In this study, we propose different methods to advance telehealth care delivery system. We also observed, due to various reasons, a significant number patients and their families preferred to be to be seen in person, even during COVID-19 pandemic.

**About the Authors**

Dr. Sultana Jahan, MD, is a professor of clinical psychiatry at the University of Missouri-Columbia, Department of Psychiatry. She is interested in pediatric psychopharmacology.

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Author Guidelines

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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.

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