DNA: Discoveries in Action Season 3 Episode 3 Transcript

Dr. Meg Benningfield: In my role, every single day, the youth mental health crisis is really top of mind. And as we continue to experience tragic events in the news and dealing with the chronic and persistent uncertainty that we've had throughout the pandemic, I think the biggest question that I tend to think about is what will a new normal look like?

Dr. Yasas Tanguturi: The whole child and adolescent mental health world is so closely related to parenting, and parenting seems to be in a crisis mode in this country. There just seems to be a lot more challenges that are ongoing, just both culturally, politically, all of those things that kind of happen. Hopefully there's more attention paid to that object in how do we help kids develop in a more resilient way, be more communicative around mental health and be able to identify things that can help wellness like you mentioned earlier.

Dr. Ebone Ingram: I think because we are kind of a society that values productivity and seem to have it all together. I think people are afraid to admit that that model is not working for them, that it is stressful. Maybe they're losing sleep because of how much they're trying to produce, or how much they're trying to do, or how excellent they're trying to look. A lot of times it doesn't look excellent.

Clark Buckner: Let's take a moment to take a breath, look around you. What do you see? Is there a breeze? Now think of someone you love, where are they and what might they be looking at? We get so immersed in our experience, it can be easy to forget that reality is an individual experience.

Then there's the magical world of children who are often exploring the wonder and mystery of life's relationships, news, and experience for the first time. And often the explanation as they come up with are funny and cute. Sometimes oopsies in the real world thrust you into the 24 hour a day world of the medical system. Let's keep that childlike magical thinking approach to this. It's a jolting experience like stumbling through a portal in a sci-fi movie. It's even more disorienting when mental health lands you in the alternative universe of the medical world.

Today, we're going to hear from three pediatric psychiatrists break down what children are experiencing, how they might be processing it, and what's happening to a system that's not equipped to triage or treat or prevent the ever-increasing prevalence of mental health diagnosis in kids. Dr. Meg Benningfield, the Director of Vanderbilt Division of Child and Adolescent Psychiatry describes the macro context of what our kids are experiencing in their daily life.

Dr. Meg Benningfield: It's really clear that kids today are experiencing much more stress related to their day-to-day safety than we had to deal with in past decades. It's also really clear that when I was a kid, school was tough, but then you went home and you weren't constantly berated by text messages, or fear that I'm being left out of a group chat, or being bullied even after school hours. And so the kinds of challenges that kids are facing now, first off they're

nonstop, it's 24 hours a day, just like our news cycle, and the intensity of the kinds of stressors that they're experiencing are so much greater. I think that one of the most important things that we can do as adults and caregivers in kids' lives is try to be able to put it in perspective. So it's important for us to talk about the things that are happening in the news using a developmental perspective.

Dr. Meg Benningfield: So the way we talk with our 16 year old child is going to be really different than the way we talk to a nine year old. And we have to really keep in mind the developmental differences between children. So every 16 year old is not going to be able to manage the same information in the same way. So really being thoughtful about what helps any particular child. Does it help to have a little bit more information? Does it help to have space to talk? Another thing that's really important for parents to keep in mind is it's really good for kids to be connected with adults who are not their parents, who the parents trust. And this can be important both for talking about heated issues where the child and parent might not agree, but it's also important in thinking about talking about suicidal thoughts. So if a child can be connected with another adult, it may be easier to talk with them about things that are just too hard to talk to their mom or dad.

So a couple of themes, one is as adults, we have to start by regulating our own responses to the big, big stressors that are going on. And then it's important for us to be making space for the big feelings. And then I think it's really important for us to remind both ourselves and remind our kids that feelings aren't facts, and some of the things that we are experiencing these big stressors, some of them may be exaggerated. Some of them may be overblown. So while the risk of being involved in a mass shooting event may be greater now than it was a decade ago, it's actually not as high as the risk of being in a car accident. These are still low frequency events, and we have to think about, "Okay, how do I make myself as safe as I can, and also decide to continue in my day-to-day life?"

Clark Buckner: How children interpret what's going on around them is a bit like walking through fun house mirrors. There is a reflection, but it's distorted and askew. Dr. Ebone Ingram, an attending physician on the Child and Adolescent inpatient unit at Vanderbilt Psychiatric Hospital, sheds light on how they often put themselves into equations and come up with scenarios that can shift blame to them. Even when there is no connection.

Dr. Ebone Ingram: I guess my brain likes to think in analogies so I keep coming up with one. But one that sometimes comes up with kids. If their parents are going through a really contentious divorce and the kid is young, they are maybe still in the magical thinking stage where they think if they truly believe if you step on a crack, you break your mother's back, they may see their parents arguing or having all of these things go on and they may think, "Oh, it's because I did this really bad thing." Or, "I got in trouble at school." Or, "They're fighting and it's about me, and I'm making them cry." And they start to blame themselves for those things. Or there may other kind of adult issues that that kid doesn't know about and they just see the after effects of mom is snapping at them or older brother is just distant.

And if they don't have a point of reference, because these are adult issues of being able to get to work on time, or your car broke down or you needed a raise but you didn't get it. Since they don't kind of have that point of reference for what some of those bigger issues are, because developmentally, most kids are still very focused on the world is in a lot of ways revolving around them, they may start to think, "Oh, this is something that I did." And then they take that, what they've internalized there and they bring it into any other setting that they're in. And it turns out to be a really huge distortion, but unless you really sit down with that kid and figure out how to trace it back and kind of correct it, sometimes you're still in hot water for a long time.

Clark Buckner: If you've ever wondered whether there's a connection between a parent's mental health history and their children, listen to Dr. Yasas Tanguturi explain predispositions, as well as what he witnesses every day in his roles as Assistant Medical Director for the Inpatient Child and Adolescent Psychiatric Unit at the Vanderbilt Psychiatric Hospital, and as an attending on the Child and Adolescent Psychiatry Consult Service at Monroe Carell Jr. Children's Hospital at Vanderbilt.

Dr. Yasas Tanguturi: Yeah, absolutely. There's a good amount of evidence in our field, especially about some of the both comorbidity for parental mental illness and kids' mental illness. There's multiple ways in which that can affect each other in some ways. Obviously there may be shared genetics in some way. Like many of these mental illnesses, depression, and anxiety, other mental illnesses have some genetic basis. There's some risk factors genetically that predispose you, not everyone, but predispose a good bunch of kids who have it to having those symptoms at the age of onset. So there's shared genetic factors, but there's also environmental factors, kind of a common kind of commodities. If there's high levels of parental anxiety, especially maternal anxiety, there's good evidence that children may have higher likelihood of having an anxiety disorder. And I think some of that is model, some of that is how the environment is and how parents respond to a crisis situation.

If there's a cultural or something else kind of going on in the world, that's pretty distressing. There's a lot of things that kids do both consciously and unconsciously in most cases pick up. So there is a lot of, not just comorbidity, there's a lot of interrelationship between that. We have known in this field for at least a good two decades now that there's a bunch of events in childhood that fall under the umbrella term called Adverse Childhood Experiences or ACEs. And one of that is kind of exposure to parental mental illness. So most of those factors, basically any form of adversity as kids, can predispose you to having a higher risk of mental illness. And so that question also kind of brings up what's been happening over the last three or four years, especially with COVID. So COVID's been a huge, huge stressor on this system. Even prior to COVID things were slowly increasing, but COVID has just added a lot more fuel to that fire and things have just gotten astronomically worse.

I think COVID worsened things for the mental health situation for children in a few different ways, the biggest reason being school lockdowns. Again, not that I'm opposed to lockdowns or

anything like that, there was good reason in certain situations for lockdowns. But I think not having the structure of school is pretty negative for the vast majority of kids. There are some kids who actually did better with lockdowns, just because that kind of eliminated some of the stress for school. Especially if you think about kids who have neurodevelopmental disorders or sensory sensitivities, for them school is such a stressful environment, that some of those did better, but that's a very small percent. For the vast majority of kids, it's been that not having a daily structured kind of setting, just staying at home, online schooling, not having some of that social kind of benefits of school. All of that has made the mental health aspect of it really worse.

And there's a lot of challenges as you mentioned earlier for schools in our country, especially in the current climate and stuff, but one thing as a child and adolescent psychiatrist, I've become more convinced of the value of school, just the value of going to school. And for kids to have that in their daily routine, it's so important. And a lot of what we are seeing right now is still kind of affects from that. Some of that is within the realm of normal, and I'll give you an example. So let's say a kid, and this commonly happens in a little bit younger kids. So think about four year olds, five year olds, six year olds, let's say they have a loss, a pet dies, or a grandparent dies. A lot of kids in that setting, a normal way of expressing the distress would be, "I also want to die so I can go be with my grandmother or grandfather."

And do they really mean they want die? No, it's more of like this feeling is uncomfortable. "I'm expressing this in this way." And so some of this will still be within a realm of normal. That would be an appropriate response to have. So again, thinking a lot about it in terms of developmental perspectives, where that comes from, and what we do see is a lot of kids who are younger and going through some of these more harder challenges. It's just not about the kid. There's also a lot of things in that environment that maybe affecting them, family life, social life, school. All of those are factors that are really important to consider or think through.

Clark Buckner: For some people who go to therapy or use digital apps to improve their mental wellbeing or awareness, the realization that feelings and thoughts are not real, the best explanation I've heard is that they're like a rainbow. You can see it, but if you manage to catch that elusive rainbow, you wouldn't be able to touch it. Thoughts and feelings are a bit like that. They come and they go. Dr. Benningfield explains why it's a big deal for parents and other adults to help kids cultivate awareness and relationships, if you will, with their feelings and thoughts. And if professional help is needed, that's not a failure.

Dr. Meg Benningfield: Two things about this. One, it's really important, especially for kids with vulnerabilities related to anxiety and depression to remember that their feelings aren't facts. The other piece about that is to remember that how we feel about something influences how we think about something. So one of the most well documented evidence based treatments for anxiety, for depression is cognitive behavioral therapy. And CBT really hinges on the idea that how we feel influences how we think, and both of those influence what we do. And that that triangle linking up how we feel, what we think and what we do, then creates a cycle where, so for example, if I have a big test coming up, it's my senior year, maybe it's my junior year, and I'm

worried about college applications and I've got a big test. This is high impact. And I start to get nervous about not doing well.

That feeling of being nervous might cause me to have thoughts that are similar to, "I'm not going to do well. I'm going to fail. I'm not even going to get into college. This is worthless. Why even bother?" And then that may lead to deciding not to study because it's uncomfortable, because I am fearful about it. And then the not studying leads to not doing as well as I want to, and the cycle continues. So if we can help kids to notice, "Oh, I'm feeling really nervous, and that makes sense, because this is a high pressure situation. What can I do that will both shift that feeling, and how can I change how I'm thinking? If I shift rather than thinking, 'I'm never going to do well enough.' If I think, 'you know what, what's most important is that I do my best.' It makes a huge impact and the longer term trajectory."

So that's just one example about how we use that kind of mantra of feelings aren't facts. That we can shift. We can shift how we think about things. We can shift how we feel about things. And the easiest thing to shift is actually, "What do I do? I don't feel like studying, but I'm going to sit down and do it anyway, because here's the long term benefits that I could see in doing that action."

Clark Buckner: The DNA team hosted a live chat a few weeks ago with teens from the boys and girls clubs of Middle Tennessee. And as you would expect, the impact and ubiquity of social media came up. Let's hear the perspective from Dr. Tanguturi.

Dr. Yasas Tanguturi: I really wanted to be an addiction psychiatrist 10 years ago, and I always felt like there's always a demand for people who can treat addiction. That's been around for so long and it's surprised me how much I'm drawn more towards children as I went through psychiatry training. And even five years ago, I didn't see how bad I guess some of this situation would get. So it's been very surprising for sure. Even five years ago, I was doing a lead search as a fellow on social media, and is there evidence connecting social media to some of the increases in anxiety and depression? And even five years ago, there wasn't a lot of data around it, but in the last five years, there's more and more data that's coming out. And I've firmly become convinced that more social media for kids is evil. I've come to strongly believe this. Back then there was still some positive hope.

These are places where some of these kids are finding community, they're finding friends, there's a lot of social benefits of it. And some of that still exists, to be honest, but there's just so many bad effects. There's just all of these horrible things that come out of social media. And if you look at timelines of when some of these increases in rates started happening, that almost lines up with the onset of social media. It lines up with when we started going online maybe a few times a day, to being constantly online. We are all constantly online all the time. There's some really good data sets that are on national level and that show that shift happened very much about four or five years after smartphones came up. So somewhere from 2007, I think was the iPhone. So like 2011, 2010, I think up until then it was still like maybe we used

Facebook, maybe used other things.

But 2011 is I think when Instagram became a thing, and that's when Snapchat became a thing. And then later on, a few years down the line, all the other social media stuff. When I see kids on the unit that are coming in for crisis and stuff, almost all of them have social media somewhere in the narrative history that we take. Like, "Oh, this happened." Or, "This kid said something here." Or, "My parents got me using this thing." Or something else happened or, "Oh yeah, I have only have two friends." And, "Okay, how often do you see your friends?" "Oh, I don't see them. They're online. I communicate with them through Discord." Or something like that. So there's always some form of their story that involves kind of social media there, which I guess we are lucky in some way to have never had it as kids.

Clark Buckner: To be fair. There are children who are doing okay, right?

Dr. Yasas Tanguturi: Yeah. Yep. And there are good parts of social media that are good advantages to kids who are LGBTQ, and there's good support systems also available online. It just gets drowned in this noise of negativity, I guess. We should just have some form off... Maybe all telecommunication companies should just shut down for 10 hours a day. We'll all be happier probably.

Clark Buckner: One of the stickiest challenges about mental health is what we think things like anxiety or depression or other diagnosis look like on a person, versus the kaleidoscope of ways they can manifest. And many times without us, observers from the outside knowing, Dr. Ingram is passionate about shifting the narrative and imagery around mental health, a vital step in making treatment and therapy routine, as in not stigmatized or overdramatized.

Dr. Ebone Ingram: Anxiety can look so many ways. I think for a lot of people, if they hear that someone's suffering with anxiety, they may have this image of someone in a corner, rocking back and forth and having a panic attack and it's very, very obvious that they have anxiety. Or they're trying to give a speech and then they suddenly stop and run out of the room like they do in every sitcom ever. But really anxiety can look like you have everything together, everything is neat and organized and the way that it should be, and you have a great poker face around it. But on the inside, you are constantly feeling overwhelmed, constantly feeling like everything is chaos, even though to everyone else, you look like you really seem to know what you're doing. I think in terms of how it relates to pop culture, I think for me, a lot of it comes down to the language that we're using to talk about mental health.

If I could just wave a magic wand and change anything around being able to de-stigmatize mental illness, I would probably get rid of the colloquial terms, psycho, OCD, bipolar, all of those things that can make a subset of people that already have cards stacked against them, feel even more isolated and less willing to say, "Hey, I need help here." That's probably where I would start. Probably wouldn't finish there, probably do some more stuff, but I'm just going to do a little free association here and say the first thing that came to mind. I don't have a couch in my

office. I'm not going to make you lie down and tell me about your dreams and stuff. I can't even interpret my own dreams. And it's not just about throwing medication at you and saying, "I'll see you back in a month." It's not really that at all.

Clark Buckner: It dawned on me that that's what people think it is. So I asked her, what is it?

Dr. Ebone Ingram: It's getting to connect with you in such a way that I may not be in the trenches of that issue with you or those symptoms with you, and that can actually kind of work to your benefit. I'm this third party that's able to be there specifically for you. I'm not part of your family and having a whole lot of other motives and other goals. I'm here for you, to be able to get to know you and understand from a third party perspective how you may be able to see some part of this differently, whether that's internal or external.

Clark Buckner: The patient, unidentified of course, that you'll hear Dr. Ingram recall next, has stayed in my mind since we spoke. The situation exemplifies why there are four episodes dedicated to mental health. It's such an interconnected, challenging struggle to alleviate and improve. It's wrenching and it's vital to understand: It's a "mental health in all policies" moment.

Dr. Ebone Ingram: Yeah. I mean, that's a really important point. I'm thinking of a patient that I had recently that I think he had basically been the victim of a stray bullet. He was walking a park, there's like a drive-by that happened and he got shot in the arm. And while he was being taken care of for his medical issue, he said something like he basically made a suicidal statement. And so he got admitted to us and it was pretty clear from the beginning that our interventions in the inpatient setting, providing a safe environment, maybe starting some meds, maybe setting you up with a therapist, when that kid goes home, he's still going to be in that environment where he was able to get shot in the park when he wasn't the target. Or he's still going to be going home to a situation where there's not enough people at home to meet everybody's needs, or there's not enough money at home to meet everybody's needs.

Even if I have the exact right treatment from a biological standpoint, I'm able to find the therapist, that's the best fit and the therapy equivalent of marriage, I'm with you forever, to go back to the dating analogy, I'm still not really doing much for your environment, and I'm not really able to change the things that are around you. I can educate a little bit, but it's not like you're suddenly going back to an environment that has changed as much as you hopefully have when you've been working with me.

Clark Buckner: You say you're fighting against the world gun. You're trying to help people be better in a world that is probably not as structured. How do you function in that environment? What is that friction like?

Dr. Ebone Ingram: I think with this particular case I'm thinking of, I think my whole team had to come face to face with a little bit of helplessness of it almost seems silly that we're talking about coping skills when you literally just got shot. I think really the thing that helps there is just being

able to acknowledge that I'm not going to be able to pat you on the back and say, "Here, try deep breathing." And that's going to be the answer. I think being able to acknowledge that and sometimes actually acknowledging that in front of the patient and family, that can help a little bit. If you're able to say, "Realistically, we're able to do what we can here, and we know that this issue is so much bigger. Let's figure out how to partner with you and really just hear you about the things that you're worried about, the things that do feel out of your control." And if all we can do is sit with you in that moment and help you tolerate it for just a couple more seconds than you could before, then it's not much, but that's what we can do.

Clark Buckner: You probably understand why that anecdote has stuck with me. The heaviness and burden and obstacles that are built into some people's lives are of course correlated to their state of mind, their mental wellbeing. What's needed to help children and teens? When is inpatient care or interactions with psychiatrists necessary? This is what Dr. Tanguturi said.

Dr. Yasas Tanguturi: I think that that's a very more complicated question. I attribute it to a lot of different factors. I work and live in this space. This is my day-to-day job, so I do extensively think about it and have a lot of thoughts about it. I have both thoughts at the same time. On one hand, I feel like, yes, all these kids are coming in and they need a lot of help. And this service that we have is an important kind of intensive service that probably needs to be expanded. But in some other ways, I also think that, "Oh wow, maybe this is not what we need. Maybe some of this need is also being generated by the fact that some of this care exists and maybe that we need to think broadly about what other treatment options there are for kids dealing with these challenges.

There are a whole bunch of other things going on, but to put it in simple words, it seems like rates of both anxiety and depression in kids and adolescents have vastly increased compared to 10 years ago. So that would be the short answer to that. But why those rates have gone up, there's a lot more.

Clark Buckner: Are there enough outpatient resources for mental wellbeing, checkups or care for the people who need it?

Dr. Yasas Tanguturi: That's easy to answer. No. But you said mental wellbeing. I think it's maybe sometimes important to kind of differentiate that from psychiatric illnesses. It's a spectrum for sure. There's a good overlap between normal states of mental wellbeing to psychiatric conditions that require inpatient hospitalization. They're both, I guess, different ends of the same spectrum. So there are a lot of different things in between. I think wellbeing is more of a bigger cultural, social, philosophical kind of discussion. We clearly have needs for both ends of the spectrum. Yes, there's not enough psychiatric beds for kids who need it. And yes, there's also not enough things focusing on wellbeing for children and adolescents.

Clark Buckner: With all the cultural talk and media coverage of mental health and treatment, are we seeing a shift in willingness to seek care?

Dr. Meg Benningfield: Certainly we've seen a reluctance and I think it waxes and wanes over time. I think what we're seeing right now is actually an increased willingness to seek treatment. But the bigger challenge is a lack of treatment resources availability. But we certainly see differences across different communities. So some communities are less likely to seek out healthcare traditionally than other groups are.

Clark Buckner: When you say lack of resources, what does that mean in real life?

Dr. Meg Benningfield: Well, it means that when a parent recognizes that they really need to seek some treatment for their child, and they start to call treatment providers, what we see is that families often reach out to their pediatrician to initiate care, to get a recommendation, to get a referral, to see a therapist or a mental health professional. And if they're not able to get in, that contributes to the escalation of symptoms that then often results in coming to the emergency room. A high number of the kids that we see in the ER show up to the emergency room because they weren't able to get an appointment in an outpatient clinic.

I think the level of distress, the thing that keeps me up at night is the short term. It's knowing that we have 15 kids in the emergency room waiting for acute care services. It's knowing that the pediatricians are just completely burned out and feeling at their wits end because they don't know what to do to help these kids and families. That's the thing that causes me the most immediate distress. But when we think about where, I think, we ought to invest our energy, it's actually in the long term. The place where I get most excited about the potential for work to make an impact and the potential for hope, is in the long term. So I get excited about the fact that if we really do focus on early intervention and identifying kids in kindergarten who may be at risk and offering preventive services.

Clark Buckner: The work that Dr. Benningfield and her colleagues are doing to improve the access points of care in pediatricians' offices with the aim of keeping kids out of crisis moments is amazing. Let's have her, the expert, give you all the details...

Dr. Meg Benningfield: And the work that we're doing in that area is to really help pediatricians understand the impact that they can make in treating anxiety as it shows up in young children in their offices. We know that anxiety disorders are the most common mental disorders in children and adolescents, and that they tend to start earlier than other disorders like depression or other kinds of challenges like substance use disorders that start later in life. And that untreated anxiety can often lead to development of those other disorders. Untreated anxiety can also lead to school failure and disruption of social relationships. So the potential impact is really huge. Pediatricians do a really great job of screening for depression in their clinical practice. And one of the tools that they have at their disposal is they are very confident using a nine-item screening tool for depression in teens called the PHQ-9.

And this is a screening tool that they can give to patients in the waiting room, and then can

review. It's a tool actually that you may have used in your primary care office. We use it in adults as well. And primary care providers have become really comfortable screening for depression, but they're not as comfortable asking about anxiety. One of the barriers for pediatricians is that the current screening tool is a 42-item screener that tries to access symptoms of anxiety across multiple domains. So unlike depression where we have this brief accessible screening tool, in anxiety, we either screen too narrowly. We just ask about worries or we miss a lot by not using that very wide screening item. So we're really excited about the opportunity to use this gift from the Worthen Family to take a data set that we already have, where we've collected data using that 42 items screener, and we've done clinical assessments with children who volunteer to participate in an FRMI study of anxiety disorders.

And we will take that data to select out what are the most important items that we need to use to screen for anxiety in primary care practice with children and adolescents. The big dream is that we would develop a tool that is easy to use and can be accessible for anyone who wants to use it, parents, pediatricians, teachers. And that through providing access to that screening tool, that we can identify kids who would benefit from treatment. And then really the next step is to be able to provide access to that treatment. So one of the reasons why this is so important is that 80% of kids who have anxiety disorders don't get access to treatment. So unlike depression, where about 60% of kids who have depressive illness get treatment, and in ADHD it's even bigger, the vast majority maybe close to 80% of kids with ADHD receive treatment for their illness.

In anxiety only about 20% of kids get treated. So there are really effective treatments, medication, therapy, or the combination of the two, all of those options are really effective for treating anxiety. And pediatricians are already really comfortable using the medications that are effective in treating depression. So one thing that's really interesting that we've learned over time is that pediatricians are more comfortable using those same medications for depression, but less comfortable when a child has the same level of impairment but it's due to anxiety. When kids have anxiety, pediatricians are much more likely to refer to therapy, which is okay if therapy is available and accessible, it's just as good as medication, but the combination is even better. And if we don't have access to therapy, medication treatment is just as good. So the long term goal would be to be able to help pediatricians feel more comfortable treating anxiety disorders in their offices, and therefore potentially prevent a lot of the downstream negative consequences related to untreated anxiety.

Clark Buckner: Helping equip pediatricians to treat would also help unlock the traffic jam created by the lack of therapy.

Dr. Meg Benningfield: If pediatricians were more comfortable taking care of the mild and moderate illness in their offices, then we could really make a huge impact. Lots more kids would experience significant benefit.

Clark Buckner: What we are experiencing in our lives, the real world is definitely taking a toll on

society as a whole. And as Dr. Benningfield put it on the live chat, which you can catch as a producer's cut...

Dr. Meg Benningfield: "Sometimes it's hard to escape all of the negativity. And when we think about climate change, and we think about the toxicity in our political discourse, and we think about the risk that we face in terms of people's rights potentially being infringed on. And is it safe to be who I am in the world?"

Dr. Meg Benningfield: The first thing I would want to say is start asking kids and families about whether fear and worries are getting in the way of being able to do the things that you want to do. Some really effective questions to ask kids are things like, do you get nervous when the teacher calls on you at school? Are you able to order your own food at a restaurant? Do you feel too distressed to go to birthday parties or go to a group activity? Do you get too scared to sleep alone at night? Asking those kinds of questions. And then reach out to a child psychiatrist in your area. Here at Vanderbilt, we have the Vanderbilt Health Affiliated Network and pediatricians who are part of that network can reach out to us anytime and just talk through a case.

And then the next thing that I would say is, as a pediatrician, if you've become comfortable prescribing medications like fluoxetine or sertraline or citalopram for depression in teenagers, think about whether you would be willing to prescribe those same medications for anxiety, because the impact could be tremendous. By treating anxiety early on, we have the potential to prevent a lot of the long term problems that we're seeing in teens.

Clark Buckner: What would our experts do if they had a magic wand?

Dr. Meg Benningfield: I think the first thing I would change is to make available the resource for kids to access psychotherapy who need it. So if I had a magic wand, I would put therapists in every school. I would across the board, make it possible for families to learn what makes a difference in kids' development, and really provide that resource.

Dr. Yasas Tanguturi: Train way more providers, both psychiatrists and therapists and social workers, therapists, psychologists, all of the above, just have more people that can do this work for sure. It's more of a medium term solution, right? It takes time to train people to do some of the work, but it seems like we clearly have a huge lack of providers to do this. There's actually evidence behind it. There's actually data to show that early intervention for anxiety, depression, other kinds of mental health challenges have good benefits as they get older. There's data that show that children or adolescents with anxiety and depression as they get older, they have not just mental health outcomes that are worse. There are also other physical health outcomes that are worse, life kind of outcome. So the amount of money you make, your job, all of those factors are also affected. So intervening in this early age can affect all of these other downstream effects down the line.

Clark Buckner: Training more people in the community evokes Dr. Aima Ahonkhai's work that

we heard about in the previous episode, Shape Shifters, to get barbers involved in care for Black men, which is a group of people who definitely tailored outreach and treatment for mental health.

Dr. Meg Benningfield: But that's a great example. And I think in particular, the African-American community is a community where there is a huge need. And historically the black community has been one that has been less likely to seek care. Black youth are at especially high risk. We've seen a huge increase in suicide rates over the last couple of decades. And a recent study that came out this summer showed a modest decrease, or maybe even just a pause in the increase in suicide rates. But that was across the whole population. That same study found a really concerning trend that in black youth and especially young men, the suicide rates are still really increasing.

So I think the idea of providing resources in the community, so reaching out to men in barbershops, is a fantastic idea. It's a great way to make resources accessible, to meet people where they are, and to really think about the potential to decrease stigma and really focus on this is a part of everyday life, and there are things that you can do to make things different.

Clark Buckner: Thanks for joining us for our second episode in our mental health and wellness series. If you haven't listened to our first episode Shape Shifters: Changing the Mental Health Story, check it out. Our next episode digs into how things like policy, digital ads, media, and imagery, and even our everyday word choice can affect a person's mental health.

To be part of the ListenDNA club, check out VUMC_Insights on Twitter. There you can participate in our live chats and you might show up in a future episode. And subscribe to the Twitter newsletter where we're convening a community as we envision the end of this season. Much like the conversation around mental health, this season is still being written. There are links to mental health resources and episode extras at listendna.com. And of course, follow, rate and review the show anywhere and everywhere you get your podcasts. Until next time, Vanderbilt Health, making health care personal.