Sanya Virani:

Hi, I'm Sanya Virani and I welcome you to Finding our Voice: Fresh Perspectives in Psychiatry, a podcast series hosted by me. This podcast has been developed with the goal to address current issues as they pertain to psychiatry, with a special focus on including the viewpoints and opinions of younger groups, resident fellow members, and early career psychiatrists. Thank you for joining me as we continue our discussions on this new segment of the podcast series about social determinants of mental health. Today's episode will focus on the impact of adverse early life experiences on mental health and provide some insights through case discussions about downstream impact of these experiences on the lives of young adults, explaining some of the flanking problems of substance use and involvement with the criminal justice system.

I would like to welcome to this second episode of the segment, Dr. Zheala Qayyum from Boston Children's Hospital and Dr. Rachel Conrad from Brigham and Women's Hospital affiliated with Harvard Medical School. Dr. Qayyum is the training director for the Child and Adolescent Psychiatry Fellowship program and the medical director of the Emergency Psychiatry Services at Boston Children's Hospital, Harvard Medical School. She holds dual faculty appointments at Yale School of Medicine and Harvard Medical School. She is triple board certified in general psychiatry, child and adolescent psychiatry and psychosomatic medicine consultation liaison psychiatry. Dr. Qayyum also serves as an officer in the United States Army Reserves Medical Corps. Welcome to the podcast, Dr. Qayyum. I am so thrilled to finally have you as one of my guests.

Dr. Zheala Qayyum:

Thank you so much. It's a pleasure to be here.

Sanya Virani:

Thank you. And Dr. Rachel Conrad is a child and adolescent psychiatrist at Brigham and Women's Hospital. She trained in the Child and Adolescent Psychiatry program at Boston Children's Hospital and completed a fellowship in bioethics at the Harvard Medical School Center for Bioethics. She is now director of the Child Psychiatry track in the BWH HMS Psychiatry Residency Program and teaches child and adolescent psychiatry to medical students, residents and fellows. She is co-director of the medical ethics and professionalism at Harvard Medical School and Director of Young Adult Mental Health at Brigham and Women's Hospital. Welcome, Dr. Conrad. It is so nice to have you on the podcast.

Dr. Rachel Conrad:

Thank you so much. I'm really looking forward to our discussion today.

Sanya Virani:

Thank you. William Wordsworth said in The Rainbow, the child is the father of man. As you would know, APA Publishing books released a book entitled Social Determinants of Mental Health recently, and it was edited by Dr. Michael Compton and Dr. Ruth Shim. It's third chapter on adverse early life experiences, which I will now refer to as AELEs going forward, authored by Dr. Carol Koplan and Anna Chard is particularly illuminating. I encourage all of you to give it a quick read because it broadens one's thinking about how AELEs are viewed. It also encompasses those elements that we might really not have thought about as belonging under the large umbrella of AELEs.

To start us out, let me point out that AELEs are defined as inconsistent, stressful, threatening, hurtful, traumatic or neglectful social interchanges experienced by fetuses, infants, children, or adolescents. These interchanges occur between the developing child and individuals around him or her in caretaking,

school or neighborhood environments and are risk factors for long-term physical and mental health consequences. AELEs also encompass a wide range of circumstances such as poverty, hunger, inequality, and discrimination. Although these broader effects are difficult to address without major societal changes. With that as our background, let's get started with the first case that Dr. Qayyum for us about her patient, Maddie. Over to you, Dr. Qayyum.

Dr. Zheala Qayyum:

Thank you so much, Dr. Virani. So Maddie is a 10 year old Latinx cisgender female who lived with her maternal aunt and uncle who were her custodians. And she presented to our clinic a few weeks ago with worsening episodes of disruptive behavior for the past month. She's made suicidal statements in this context, but it was otherwise doing well in school, making progress through the fifth grade. Maddie was raised for the first few years of her life by her biological parents who were not married. But eventually they separated when Maddie was six because of domestic violence, which Maddie and her younger brother both witnessed. Maddie's behavior during that time of change resulted in some anxiety which led her to seeing a therapist briefly at that time. Her mother though had struggled with her own mental health and substance use issues, which worsened afterwards and therefore therapy stopped at that time.

Sanya Virani:

That's a grim beginning, but also one that I imagine child and adolescent psychiatrists have as often-encountered scenarios in their clinical practice. No. So what was the extent of this domestic violence, Dr. Qayyum, that Maddie and her brother witnessed. And further, I was just curious, were they subjected to any form of abuse by their biological parents themselves?

Dr. Zheala Qayyum:

It was unsure to really substantiate if they were abused by the biological parents because some children can just be very secretive about it because violence is a difficult experience for children. What we do know is that Maddie's father would often be intoxicated and hit their mother. Once he pinned her against the wall and threatened to kill her while the children were still in the room. Their father would yell at them, which Maddie reported was very scary for her. But it's not uncommon for children who are removed from their parents to still have an idealized image of that life, that life was better then, or that they would like to be back with their parents who would actually abuse them. It's a source of great conflict and ambivalence for a child to be hurt by the people that they rely on for protection and nurturance.

It is hard not to know what kind of parent you'll have that day. Will it be the intoxicated one, the distant one or the loving one? And even scarier is the fact that you are worried about harm coming to one of your parents because losing a parent is one of the biggest fears a child can have. What we do know though is that Maddie's most recent boyfriend who had moved in when Maddie was eight, came with a hoard of problems, most important of which was heavy use of various substances. And eventually the school filed with Child Protective Services when they became cognizant of the concerns about substance use and the home and the mom's boyfriend's legal issues that even resulted in police coming to the house. When we spoke with Maddie, Maddie recalled having nightmares and anxiety that led to difficulty going to school at that time. But she said that these symptoms did not last very long and eventually resolved.

Sanya Virani:

I see. So this really got me thinking all these insightful comments about how children interact with their parents and how we can be set up for a very unpredictable type of upbringing, so to speak. I just wanted to pause at this juncture and give our audiences some tidbits that relate to these aspects of AELEs or ACEs, adverse childhood experiences. The latter being sometimes considered to be a subset of the former. So the ACE study pyramid is actually a model which is explained by the Center for Disease Control and Prevention. They explained that out in 2013 and illustrated the progression from ACEs to adolescent risk behaviors to adult disease, disability and social problems, and finally to premature death.

Now, if I look at this pyramid actually, which goes from the base to the top as from conception to death, it proceeds in the following way. Adverse childhood experiences at the bottom, social emotional and cognitive impairment, one leg up. After that adoption of health risk behaviors leading to disease, disability and social problems. And finally to early death like we were saying before.

But more importantly, the ACE study researchers actually explained that these behavioral risks often begin as a result of adolescents coping with chronic stress, which stems from early childhood trauma. So in a study examining the relationship between ACEs and ischemic heart disease, researchers found that not only did risk increase one's ACE score, but also [graded relationships existed between one's base score and more proximal risk factors such as smoking, physical inactivity, and severe obesity. Some risk factors are efforts at self-medication through the use of substances such as nicotine or alcohol that provides psychoactive benefits.

Now this finding is significant in demonstrating that a AELEs precede the development of many traditionally accepted risk factors for chronic disease, and therefore the recognition of this association opens the door for more robust chronic disease prevention, research and activities. And finally, I will say that the ACE study and many subsequent studies have provided strong evidence implicating childhood abuse, neglect, and family dysfunction as social determinants in a child's environment leading to negative physical health and mental health outcomes throughout the lifespan. And these studies importantly are suggestive of a dose response relationship where the risk for chronic conditions such as ischemic heart disease, cancer, COPD, and autoimmune diseases, hepatitis or jaundice, skeletal fractures increase in greater fashion as one's ACE score increases. And with that, I'm going to turn it back again to Dr. Qayyum who will take us further along Maddie's story.

Dr. Zheala Qayyum:

So what we found out was that a year ago during a police force visit to the house, drug paraphernalia as well as unsecured loaded firearms were discovered in the home. So as a result, Child Protective Services became involved in a protective capacity and both children were removed from the home and their mother. Maddie's mother was asked to engage in mental health and substance abuse treatment while Maddie and her brother was separated. Maddie was placed with her maternal aunt while her younger brother was placed with the maternal grandmother.

Sanya Virani:

So Dr. Qayyum, for the information of our audiences that might like to have some clarification about the petition and court processes, would you please point out who the key stakeholders in the game were?

Dr. Zheala Qayyum:

Sure. So Child Protective Services, and this depends on each state, can get involved in either a protective capacity, and that is when they get a report, which they investigate, and if they find grounds for

concerns that substantiate the report, they may intervene to provide services to keep the child with the family. But if there are grave concerns, they may remove the child from the home.

The other case is when the family needs services to care for their child and is unable to provide those services and they voluntarily ask for help from Child Protective Services. In the first case, which is the more protective capacity, the child protection team goes to the court to either take temporary or permanent custody of the child if they need to remove that child from their home. And they need to do that so they can assume guardianship and be able to place a child outside the home. It is always preferred and it is the goal of Child Protective Services to place the child physically with family members first rather than strangers.

Sanya Virani:

I see. And this makes me think back to my current fellowship actually that I'm doing in forensic psychiatry and I work with some juveniles for at least one time a week. And I have seen many of them who hail from very chaotic households and they sort of end up being placed in court ordered residential treatments either at a residential treatment facility or a group home, which essentially are two different levels of care. Albeit this is almost never akin to involuntary confinement of sort. And by that I actually mean that the kids, and I'm alluding more to the first situation you described, Dr. Qayyum, can actually leave the group homes if they choose to.

However, I have always seen that proper follow-ups are carried out by CPS even after to ascertain their safety, meaning they may run away from the group home. And then depending on their age and legal status, there may be consequences for that. Some are considered secure. That means the group home is considered secure as in lock. Otherwise staff secure, meaning someone will try to stop them by restraining them if they try to run and others are open. But I agree that the first preference is to attempt to mediate reconciliation with family members. And in cases of divorces there are supervised and graded visitations permitted with special attention to the management [or substance use disorders that either of both parents might have as you alluded to before, in this case of Maddie, Dr. Qayyum.

Dr. Zheala Qayyum:

Over the past year, Maddie's been doing well overall adjusting to living with her aunt and has regular visits with her grandmother and brother. However, in the past month, this oppositional behavior has worsened and she's had episodes where she was throwing things in the room. Maddie also reported that during these episodes, her aunt yelled at her and even once hit her on the back. It seems like this change in behavior appears to have started once Maddie heard that her mother was going to start visitations again with possibility for eventual reunification. Although there were occasional visits by Maddie's mother before, these were pretty inconsistent in the past. Now Child Protective Services was formalizing the visitation since Maddie's mother had completed the requirement for substance use treatment as had been asked of her by the court. This was planned to be the first step, more supervised visits and eventually, if that all went well, the goal of Child Protective Services was to unify the children with their parents if this can happen safely and if it's in the best interest of the child.

Maddie seems to be more anxious. And during these episodes when she's been upset, she's been making suicidal statements. But she's had no self-injurious behaviors or any previous suicide attempts. She has a loving relationship with her brother and doesn't like getting into trouble for her outbursts. She used to have a good relationship with her mother, she described. But Maddie has somewhat of strange relationship with her aunt currently and doesn't like her aunt yelling at her. So I think Maddie would meet criteria for post-traumatic stress disorder earlier in her life. But at this time, she's having difficulty with adjustment with prominent features of anxiety.

Sanya Virani:

Dr. Qayyum, thank you so much for that. And clinical pointers for those listening in, the DSM-5 recognizes V codes for child neglect, child physical abuse, and child psychological abuse. And more descriptions are available on page 715 in the category of problems related to family upbringings, parent and child relational problems. Now finally, might I ask you the overarching question that I've had in mind since you started narrating this case? Maddie seems to be in a decent place in her life right now. But many children who have been through her kinds of experiences and subjected to multiple placements and DCYF involvement, their outcomes might not be as good, no, because of repetitive or shall I say, cumulative trauma. What do you think, Dr. Qayyum?

Dr. Zheala Qayyum:

I agree with that. Trauma and especially chronic developmental trauma, what you called cumulative trauma, can really throw a child off the normal developmental trajectory. As you described before about group homes and placements, many children end up with multiple placements, some of them in foster homes. And they lack consistent caregiving, so that doesn't allow them to get opportunities to develop long-lasting relationships. It's also important to consider that these children are not always experiencing trauma and isolation. Sometimes their families are also experiencing challenges like their own trauma, financial hardships, housing and food insecurities and other things that makes finding stability even more difficult. This is why treating a child who may have all these additional risk factors requires so much care and support to ensure that we can intervene now because if left untreated and these issues are left unaddressed, then the lack of being able to form stable relationships or to continue having behavioral dysregulation or mood symptoms or other things can persist into adulthood with higher rates of psychiatric illness and predisposition to substance use issues.

Sanya Virani:

Yeah. Thank you so much, Dr. Qayyum. Exactly. And this upstream intervening that you just alluded to makes it even more clear as to how AELEs are actually really, they're social determinants of mental health in the long run. With that, let's move on to our next case about Sarah that Dr. Conrad will tell us about.

Dr. Rachel Conrad:

Sarah first came to my clinic at age 23 struggling with depression. She described that every morning she felt like, "I don't look forward to anything. Damn. I'm awake. It's never something that I want to do. It's something that I have to do. It keeps me in bed for hours just dreading the day." I learned that Sarah's depression first started during high school while living in a scary and confusing home environment, and she has struggled with depression since then.

Here's what I learned about Sarah's time growing up. Sarah's father would sometimes come home late at night, rambling loudly. From time to time, he would have unpredictable inexplicable changes in his emotions and behavior. He sometimes hit her and her siblings and at other times would starve them. Sarah's parents were divorced and her mother didn't show such terrifying behavior, but her mother was distant and disengaged.

Despite the chaos in her family, Sarah still felt close to her brother and her grandmother. During her teenage years, Sarah dreamed of cutting herself or calling 911 to get away from the home. Rather than live in this unsafe environment, she eventually ran away and she became homeless during high school. Teenagers in this situation are vulnerable to sexual trafficking because they have trouble distinguishing people who are safe from those who are unsafe. Traffickers are initially charming and take care of their

future victims. However, rather than falling into the dangerous trap of trafficking, Sarah did find safe people to help her. Finally, a friend's parents got guardianship of Sarah when she was 17.

Now, fast forward to 2021. Sarah still struggles with overwhelming emotions and difficulty coping during stress. This is common among people who experience childhood trauma when they weren't taught by their parents to recognize and soothe painful feelings. When she becomes overwhelmed, she has intrusive thoughts about her own death and struggles with nightmares. Despite this, Sarah studied art in college and that became a haven for her to express her feelings. She's worked with the same therapist for many years and she's kept close friends. Many people who experience abuse in an intimate relationship are not able to trust or feel safe being close to others. It's possible that her childhood relationships with her brother and grandmother taught her these critical skills.

Sanya Virani:

I see. Thank you, Dr. Conrad for explaining Sarah's case to us now, and also bringing up those very insightful points about the trafficking and the inability to form relationships based on trust and safety concerns at the background. Much like Maddie's case, it's also very nice to hear that Sarah found a way to cope. But the path to recovery, as I understand it, can be a rocky one. And many times I feel like there are ups and downs and things don't really remain steady in the lives of these vulnerable children. Did you see any fluctuations in Sarah's case?

Dr. Rachel Conrad:

Many people who live in a traumatic home environment as a child have more difficulty recovering from an episode of depression. Sarah's depression was particularly challenging to treat. Unfortunately, like many other college students, Sarah experienced sexual trauma during college. Then she was left struggling with both childhood trauma and sexual trauma. However, Sarah continued to work with her therapist to recognize her emotions and build close relationships with trustworthy people. This helped Sarah to recover from depression and PTSD. In addition to medication and individual psychotherapy, Sarah attended group therapy, support groups and received support from the few trustworthy people who were in her family, including her brother and grandmother. Kind and generous friends supported Sarah's treatment and would even engage in safety planning to prepare for moments when Sarah couldn't cope safely. Sarah began to support other people who were struggling with depression and PTSD. Sarah navigates her illness gracefully. She's pursuing passions and building a rich and meaningful life teaching art. Sometimes people call this process of recovering from trauma post-traumatic growth.

Sanya Virani:

Thank you so much, Dr. Conrad. Post-traumatic growth. I had never personally heard of that term, so thanks for bringing that up. And for final closing thoughts on this case, Dr. Conrad and Dr. Qayyum, after that, I'll ask you both, what might a clinician draw, what kind of learning would they draw from these kinds of cases while working with patients through their various challenges over several years at a time like you guys do?

Dr. Rachel Conrad:

Like Dr. Qayyum mentioned, the unpredictable behavior of a parent and overwhelming emotions are often traumatic to children. These children will then have trouble identifying who is safe and trusting that others care about their feelings. People who experience childhood trauma often rely on ineffective coping during moments of this overwhelming fear and sadness. They often shut down, disconnect from their feelings and freeze when they should be seeking safety. This type of coping can be dangerous and

lead them to experience more situations that can make them vulnerable to more trauma like happened to Sarah. However, both Maddie and Sarah had a few close relationships during a traumatic childhood. Studies show that even one close relationship can help a child who is living with trauma to learn how to cope with difficult feelings and build safe trusting relationships.

Sanya Virani:

Thank you for those comments. I'm sure that if any clinician is listening to this, they'll probably be taking notes at this point to think about inquiring about the few good relationships which vulnerable children might actually develop through these times of trauma. What about you, Dr. Qayyum, any pointers?

Dr. Zheala Qayyum:

I think it's helpful to always explore trauma as contributing to psychiatric illness or any presentation, even if we haven't put that in our differential or consideration because they don't always surface and people are not always open to exploring them or talking about them. And oftentimes childhood trauma, in particular, can be difficult because children might not even have the language or the vocabulary or the cognitive ability to understand and be able to cope or process that experience. So a lot of it might surface later on in life. So I think that is an important background to have that when we're treating people with psychiatric or mental health issues or even substance use issues, that trauma can have a lasting impact. And unless those issues are addressed, then just scratching the surface and treating symptoms might not actually result in the kind of healing and recovery that we would hope for our patients.

Sanya Virani:

Thank you. Thank you so much. You put it in such a nice way. So thank you so much both of you, for your suggestions, for your comments. And with that, we have come to the end of the ninth episode of Finding Our Voice, the second one of this new second segment dedicated to issues of social determinants of mental health. My deepest gratitude to our guests, Dr. Qayyum and Dr. Conrad. We are so thankful for your time, the stories you discussed and the insights you provided. We really enjoyed learning from you about your various experiences and your perceptions of AELEs among your patients and greatly value what you have shared with us today. This discussion can certainly find a lot of application in day-to-day clinical practice. Thank you.

I'd like to leave you with one final thought. Elizabeth Kubler-Ross, the celebrated Swiss American psychiatrist once said, "I have never met a person whose greatest need was anything other than real, unconditional love. You can find it in a simple act of kindness towards someone who needs help. There is no mistaking love. It is the common fiber of life, the flame that heats our soul, energizes our spirit and supplies passion to our lives." Thank you.

Finding Our Voice would not have been possible without help from Dr. Francis New, my mentor who has been on this project with me, guiding me at every step along the way. And finally, I'd also like to thank APA Publishing for being instrumental in recording, editing and releasing this podcast.

Speaker 4:

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