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THE LEARNER'S VOICE

Healing Through Listening

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It is February and one of the coldest days of an otherwise warm and dry winter in New York City. I am sitting in a second-grade classroom in Public School 128 as part of my last medical school rotation, a child and adolescent psychiatry elective. The lesson of the hour is "social-emotional learning," and the children are set to get their chameleon stuffed animal, or "Cam," today. The room is brewing with excitement. Cam's job is to help students name their emotions, and the chameleon will take on the emotion the student is feeling in that moment. "I gave my Cam the name Rose because it is my favorite flower and makes me happy!" a young girl exclaimed to me, shoving Cam in my face. The social-emotional learning curriculum these second graders were participating in is designed to serve as preventative mental health education, which has been shown to improve emotional well-being and social skills as children get older [1]. All elementary school students in New York City Public School District 6 are taught these skills as part of an effort to combat the growing adolescent mental health crisis [2]. The young girl was later able to identify that she was feeling upset, and Cam also became upset, rallying her classmates around her to cheer her up. "You can tell they've been doing this since kindergarten," the school psychologist told me.

The following week, I am sitting in the pediatric emergency department (ED) workroom. The ED is jam-packed with crying kids with fevers. Respiratory syncytial virus is going around, and it is the height of the influenza season. The child and adolescent psychiatry team monitors the boards for a different kind of chief complaint, though. "Suicidal ideation." "Eloped from school." "Violent." The child and adolescent psychiatry fellow and I go down to see the newest patient, a preteen who was presenting for the first time. She had told her school counselor that she was feeling extremely sad and did not want to live anymore because she was having intrusive and scary thoughts about something that had happened in the past. When her mother took her to her home country a few years ago, she said, her mother's boyfriend abused her. The trauma she experienced as a young girl, one of many risk factors for adolescent suicide [3], had re-emerged into her developing consciousness.

As we walked in to her room, I immediately noticed the numerous thin, faint scars lying in parallel along her left forearm. We started our conversation gingerly, asking about her favorite subjects in school and what she likes to do for fun. "Math, basketball, Nintendo," she said. Reassuringly, she had warded off significant anhedonia, a poor prognostic sign of depression. After developing some rapport, I gently moved to the reason she had to leave school. "Are you having any urges to hurt yourself?" I asked matter-of-factly. I was taught that being straight to the point is often the most effective way to get a truthful response, but it still has not become easy to ask this question, especially to a preteen. Part of me hopes it never will, so that I give it the importance it holds in every interview. She blankly acknowledged her suicidal thoughts and said she cuts "to get rid of the pain," a common reason among individuals who self-harm [4]. Here she was trying to identify an emotion and developed an unhealthy coping mechanism, an outcome the local public school curriculum was trying to prevent.

I found myself at a loss of words for what to say next and turned to my fellow to carry on the conversation. The psychiatric interview is an art, one I had not yet fully mastered. The fellow reassured her that she was safe here, it is okay to feel sad, and we can help her. A sense of relief subtly but noticeably washed over her. Unfortunately, she would need hospitalization, which meant she would sit in the ED for days until a bed in a child and adolescent inpatient psychiatric unit would open up somewhere in the city. All across the five boroughs, adolescents and teenagers are filling up these beds, in the worst mental health crisis this country has seen, the cause of which is still not fully known [5].

The next month I matched into psychiatry residency. As my fellow future doctors and I sat in Central Park and

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savored the early signs of spring, I could hear the squeals of kids running around nearby. I thought of all the children I saw the month before, who were struggling to carry on their days. I would soon be their doctor. Much like the children at Public School 128 learning to express themselves, I too will learn how to express myself to nurture my patients' recovery. I thought of the fellow who had a calming effect on the adolescent in the ED. How did the fellow know what to say? I realized the fellow simply yet skillfully named exactly what the preteen was feeling, and she felt heard. It soon became clear: Words are the tool of the psychiatrist, and knowing which to use and when is the highest challenge. What will patients want to hear from me, I wondered, and how will I tell them what they need to hear? These are the questions I hope to answer in residency. Despite not knowing yet, I take comfort in the fact that I will listen to them in their moment of crisis, so that they no longer suffer in silence.

Declarations

Although the manuscript describes the care of a potentially identifiable individual, all potential protected health information identifiers have been removed and the manuscript adheres to ethical considerations and confidentiality standards.

Disclosures The author states that there is no conflict of interest.

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