Raising Resilient Teens: Adolescent Mental Health, Treatment, and the Parent–Teen Connection with Dr. Sarah Sicher, MD Transcript

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Introduction and Guest Background

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And I'm Dr. Surya Ravan. With the wisdom from holistic, alternative, and these conventional medicines, we are here to challenge the status quo. We're curious about the connectivity and complexity between diverse fields of knowledge as it relates to consciousness, chronic illness, mental health, resilience and beyond.

Learning more about The Art and Science of Healing. So welcome to another episode of the Too Curious, Emny podcast where medicine is more than science, it's story, art and connection.

Today we have another special guest, Sarah Seischer. It's like Fisher with an S. Yeah, it's beautiful. She's a board certified adolescent and child psychiatrist whose practice integrates psychotherapy, medication management, and a whole person approach to mental health.

And she's a ketamine assisted psychotherapist, psychiatrist in Los Angeles. And, she is also providing TMS treatments for the adolescent and young adult population.

So, we're keenly interested in learning more from her about her experience in adolescence, recognizing when a need, when the need comes in. the professional help, what's the most effective and developmentally appropriate treatment and how to really approach that treatment, especially in the adolescent and young adult population, because I believe they have a different set and setting, call it, or different brain, you know, a different experience.

And also there's a lot to talk about when we talk developmental effects and the family dynamics that shows up in treatments. So thank you for being here, Sarah.

I'm very happy to be here. Thank you for having me. So what initially drew you to child and adolescent psychiatry? So I have a background in pediatrics.

I didn't finish a pediatric residency, but I started one. And I sort of knew in towards the end of medical school that I was interested in working with.

children and adolescents. I think there's a part of me that can really still identify with the adolescent part or that's very accessible and so it makes the work a kind of natural fit.

And I've also always been very, very interested in development and kind of how development trajectories are more than linear and multidimensional and unfold throughout our lives.

And, I like kids, always have. Yeah, I definitely agree with that. Being a pediatric hospitalist in training and now I'm doing adult medicine, mental health care, and I see the child and the adult now more so.

Exactly. It's like that, I think it's Ursula Le Guin that has a quote, like the creative adult is the child who survived this sort of idea that we grow up with this narrative that you reach adulthood, you reached some point that you'll be an adult, you know how to do things, have it all figured out.

And it's such an untrue narrative, and such in some ways a damaging narrative. But I certainly think there's something very healthy about keeping that playfulness, the ability to play, to engage in the world in that way.

Yeah. Alive. And to stay creative, I think. We talk about this in our work too, neuroplasticity, the effect of neuro plasticity. What changes from the child brain to the adult brain has an effect.

Why Child and Adolescent Psychiatry

losing that explorative way of thinking, you know, the openness, intrigue, curiosity, creativity that children have when it becomes the adult kind of restricted in just the default mode system and operating through that.

What have you learned from working with teenagers and young adults in your practice currently, knowing the current environment of mental health, Um, well, it's so much.

I mean, I think that, A, we were talking a little bit before the show about the systems being really broken. And I, think, that's an understatement. Um…

I thing, um, psychiatry in particular, and psychiaty for children and adolescents in particularly, has, uh, really not evolved at the pace that the experience of growing up in today's world has changed and evolved, right?

And we see this discrepancy all over medicine where the real world is sort of like outpaced the research and regulatory world. And I think in child psychiatry, it's so hard to do studies, and I'm not a researcher, I am a clinician.

And what I see is it has always been very hard for me to grow up. It's a daunting task, whatever that means to you to grow up. But I think in today's world with technology, with changes in the economy, and with the difference in expectations of what it is to launch out of the home after schooling, how competitive schooling has become, social media, with technology.

I mean, they're literally living in a different reality than we grew up in. And it's obvious in the numbers and the data that they are struggling. I think what I've learned is that people come in with a very similar story often of feeling like they are terminally different than everybody else.

that they don't know how to connect with people, that, they, don, t know, how, to sustain relationships. They don t know. How to interact. they. Don't.

Know. Okay. I have a lot of teenagers, surprisingly, who, like, I was surprised when this started coming up, but, won't order food, on the phone, They're terrified to talk to somebody to order, food because they've learned to do it all.

on an app where they don't have to interact with another human being. And I think this isolation while being in proximity to other people is a common experience of adolescence always, but I kind of environmental and technological changes.

And I think drives actually a lot of the increase in mental health issues that we see. Yeah. Isolation, but still in proximity with other people, you mentioned.

Yeah, that's sort of like, what is connection? Like, is a friend that you make on a video game? What is the difference in the sort-of quality and fabric of that connection from a friends that make in real life?

Or not in life, like in person, where you're sharing physical space and… Yeah, it creates a kind of a different kind experience of living and understanding of just even the access to technology and yet you're in the same room and no one's talking.

Exactly, exactly. Yeah. Yeah. Definitely can see that as, you know, just observing people. You know sometimes when you go on a train or in a subway station, there used to be a time when everybody used have a book or,

listening to music or talking and then if you take a picture of that and translate it from, the 80s to the 90s, to 2000s.

Suddenly, now everybody's on their phone and no one's looking up. No one even cares. And so there's definitely a disconnect in proximity with other people and that itself creates a sense of isolation, depression, not knowing, I imagine.

Teen Mental Health in a Digital World

And I think an increased sense of self-consciousness, right? Because you have this edited version of the self that is displayed publicly. And so these old ideas from old developmental specialists and analysts about false self and true self, I think it is just amplified.

The volume has turned up on that tension so much because not only do you have the opportunity to edit what version of yourself you're putting out in public, but then you also get real-time feedback.

real-time rejection or real time validation and I think it's really my theory you know like the triune theory of the brain which is the reptilian brain the mammalian brain and the cortex I have this idea that like that the human brain will change anatomically within the next like a couple of decades, like very, very rapidly because of how we're interacting with our environment.

Yeah. That's already happening. I mean, how many things can people remember now versus what they used to? Exactly, attention spans. The attention, everything's much more fast-paced.

You can't watch a show that's slow or old school and people are just used to a certain way of getting information. A quickness of dopamine and this conversation.

I had it four times today. And with patients, it's sort of like fast versus slow dopamine. And that it really difficult, especially to like a 16 year old, to be like, you should pick up a boring book and read it.

But it is so boring. I'm like yeah, that's so, like do it anyways. Well, what do you, how does this show up? How are these conditions that we're living in or young adults or teenagers are living and show in their mental health that you see that require treatment?

So I do, because I'm child and adolescent board certified, I see a lot of ADHD. And I think the discussions around ADHD, what qualifies as a disorder, would we all have sort of symptoms of diminishing attention spans that are, I happen to believe that it's related to sort late-stage capitalism trap where that's exactly what is meant to happen when you engage in these technologies on a regular basis, is that you're training your brain to rely on immediate hits of dopamine, small hits dopamine on the regular bases, and that kids are spending much less time outdoors, much time interacting with nature.

much more time in imaginary worlds, which for some kids is developmentally appropriate, but then at some point it becomes less developmently appropriate.

And so there's this, I think, odd thing that happens where kids are more connected in some ways, like they're always plugged in, But they are less connected, in meaningful ways.

And so with ADHD, there's been a lot lately about girls with ADHD and the difference in presentation in girls. With ADHD and I've seen a of that in my clinical practice, including older women who feel like they were missed sort of or overlooked.

And then a lot of depression, anxiety, and school-age kids. I think the repercussions of COVID are echoing still, even though it's, what, six years behind us, like, that those years and the effects that they had on these kids are still profound in their development and their social development.

And then I live in Southern California, so pot is everywhere, but it's not like regular pot. It's like 95% THC pot, which

is psychomimetic and much more dangerous.

And it was just the access that the teens and young adults have to I mean, they've always had access to marijuana, but it's a different game. I would argue that it is an entirely different substance, in fact.

And then how does that show up? I see a lot of more confusion about whether marijuana is being used to self-medicate or to treat certain symptoms like insomnia or anxiety, and then how that sort of snowballs into unhealthy relationship or dependency on the substance.

A lot of cannabinoid hyperemesis syndrome developing. And then psychosis. Kids, there are certain populations who are at higher risk for psychosis anyways, but the high concentration THC products are so much more likely to trigger a psychoses that I just find it to be that the effects are much dangerous and end up leading to much acute situations.

Yeah. And in a developing brain, you mentioned, a mental health kind of showing up at different developmental stages and the effect that kind has on development.

But in particular, with any type of substance exposure, what effect do you feel that has Yeah, so there are two things. Actually, my first association when you asked the question was about eating disorders because I've seen a movement towards younger, the development of especially anorexia in younger people.

So it used to be that we'd see it usually around like 12, 13. And during COVID, I started seeing it eight year olds, 10 year old, and there have been some meta-analyses and trying to figure out why this is.

And the thoughts are sort of around like social media and isolation and being on Zoom, even seeing that there's a draw towards a hyper-focus on one's appearance, if you can see your face on camera.

But in terms of the substance use, the data is very clear that adolescence is a time of pruning neurologically. And I think what happens, and it also interferes with learning, I What I see is there ends up being a really intensified struggle around differentiation of the adolescent and the parents being scared out of their minds about what it's doing to their kid.

And the kid having, the young adult, having very little insight because they think that it is medical, it serving a medical purpose. And they're getting conflicting information from the internet and different websites.

And I think the adolescent brain is particularly vulnerable to injury neurologically. It's robust. I mean, kids are more resilient than we give them credit for.

I think particularly the adolescent brain is vulnerable to developing these sorts of tracks, right? And that's where ketamine comes in, that we have some opportunity to Instead of entrenching those maybe negative tracks, even further giving individuals an opportunity to maybe make some new, take some directions, have some adjacent possibilities.

Yeah. So what's your view on ketamine as a treatment? I mean, ideally in adults kind of we use it for treatment resistant depression, right? Two to four drug failure, you know, other alternatives, not working, side effects, something that requires, again, another modality of treatment.

That is for one kind a cohort of patients. But what is your views on Ketamine for adolescents and young adults? being the first line treatment.

ADHD, Anxiety, Depression, and Substance Use

So I, that's very interesting. I don't think I've ever used it as a first-line treatment, but there are times where I will bring it into the conversation earlier than let's try a different SSRI, for example.

we have these blind spots in psychiatry. For example, in adults, there's been a lot of research on the sexual side effects of SSRIs on adults. And the numbers are that really large percentages of adults who are on SSRIs have sexual effects where they have decreased libido, decreased sexual functioning, decrease stability to orgasm.

Now, if you have a 16-year-old and you wipe out their sex drive, that to me is a huge developmental problem because their experience of themselves and their body and their experience of themselves as that those are normal psychosexual developmental experiences.

And I don't think we know enough yet. We haven't researched it enough to know what the implications of that are for young people. as opposed to somebody who's established their relationship with their body and with her sexuality.

But in particular, I think I've found ketamine, so I'm not a cowgirl, like I am still pretty conservative with how I use it. and it's off-label for adolescents.

I've treated some older adolescents, but I found it very helpful in acute suicidality to prevent hospitalization as probably one of the most kind of practically helpful ways.

Um, I have had a few patients where I combined starting a low dose of lithium at the same time for the anti-suicidal self-harm effects, like a sub, not a mania dose of lithium, but like 150, something like that.

And then the way I do ketamine, my practice is once weekly, usually on a Friday for three weeks. I work with a therapist who does integration and prep work.

that I feel like we have successfully kept several patients from having to go to the emergency room and be hospitalized. And that always, to me, feels like a huge win because I guess it's all circular.

But the system is so broken that oftentimes going, sometimes it is necessary, but sometimes going into the systems of that is really, really traumatic.

Yes. A lot of times, even our type of patients were treating that history of that exposure. Exactly. It's a medical trauma. Yeah. And there has to be a better way to treat.

even, I mean, you mentioned, and thank you for bringing that up about the development, hadn't thought of that before, as the sexual side effects being a component of an important part of development and the relationship to body that it can have.

So I again pose the question, right? If something is doomed to failure, which kind of we see when this arises and the stacking of medications, and then by the time the fourth line treatment comes in, you're not effective at all.

Why even bother with that line, that algorithm, I call it. When the efficacy of ketamine, even in comparison, if it wasn't used for post-treatment depression, why not just start with that?

Because the advocacy is better, as you compare the two. One of the things I consider with ketamine is the durability of it and concerns about durability because while I have found it, I think the data supports this too, that it's very, very effective and very safe.

It's been around for a long time. We know lots about it. we know a lot about safety profile of in all sorts of populations, right? Kids, people with comorbid medical conditions.

So I have been very confident that it's a safe drug and in some ways probably safer than, certainly safer, than like a second generation antipsychotic in a lot of ways.

But it doesn't really have the data to support durability. And I think for, and that's where TMS kind of comes in, because Tms is a little bit the opposite.

Like it does work right away. But it has evidence for much greater durability. So there's some interest in emerging research about the relationship between ketamine and TMS and how you can combine them or not combine.

Yeah. Well, give us an idea of how do you decide on modality of treatment for the adolescent or young adult. What's your approach like? For our audience, what would be your approaches for treatment?

What is required in preparation? And also making that assessment of choice between which option would the best. in a supporting? So I think one of the first assessments is the family structure, right?

And that's one the biggest differences between doing child and working in adult populations is that really the child's family environment is of utmost importance.

So what does the familiar environment look like? Is it a family who can communicate effectively? Are they open? are they supportive? not presence with a T, but presence, like their psychological presence.

Like how informed are the parents? How open are they? And then how stable are, they right? Are they dealing with substance use disorders? I think that context really can sway because I mean, a ketamine in a younger person really requires a holding environment from the family that is different than doing ketamine work with an adult.

I guess some of it is acuity. If a patient is really acutely suicidal or really, really acute depressed, they need something that's going to be immediately effective, I would reach for ketamine first.

TMS is tricky because it's a very good example of where the sort of clinically and industry outpacing research and regulation. And so the only FDA approved indication for T. M. S.

is treatment-resistant depression. Some machines are approved for OCD, some are approve for smoking cessation, but all machines really can do the same thing.

One of the big differences is whether they use functional MRI or not, or different type of neuro-navigation. And then there was two machines that were approved for 15 and up.

But the other machines can do the same protocol. And so there's nothing particularly special about those machines. It's just, again, it circles back to this idea of the system being what other forces are at play that influence decisions.

Yeah, I mean, the marketing around the machines as well as what's been cleared and what is approved, FDA approved versus cleared. Exactly. It makes it very tricky for providers as for patients.

And it puts this kind of question in, you know, is a machine capable of treating the patient or is it a dose treating a patient? So tell us a little bit more about that for our audience.

Yeah, so I ended up, I was interested in getting more exposure to the world of TMS, but as a solo private practitioner, it's very hard because the machines are very expensive.

Tms has been around for a long time, Um, a lot of it is sort of like still rooted in research based. So, um, the machine, older machines are sort like, they're a dental chair with like a, this hood and it's bulky and that costs a lots of money and, uh, you have to have staff to run it.

And I am not, I'm a one person in an office.

Ketamine for Adolescents and Young Adults

And so a couple of years ago, I heard about a machine called Ampa. That's a company up in the Bay Area. And they developed a portable machine. So it's actually portable.

It's like 40 pounds. And it fits in a suitcase, so it can be moved to somebody's home. It can move to a treatment center. Like it really is legitimately portable.

I've taken it to other places besides my office. And there's a little bit more flexibility in how the patient can be during the treatment. So they can, like in my office, I have a massage table that goes up.

It really can prioritize patient comfort in a way that some of the other machines can't. And then AMPA did their own studies on, there's a lot of interest in accelerated TMS.

So traditional TMs is usually 36 sessions over six to seven weeks. That's the kind of Tms that's covered by insurance usually. And, and then in like 2000, So the research started 2008, 2009, and 2014, 2015. The same protocol was FDA approved.

That was a compressed protocol through Stanford. And then AMPA did smaller sample size research on working on the parameters that could compress the treatment even further.

medication augmentation with a medication called D-Cycloserine, which is an old tuberculosis drug. And then there's, mm-hmm, yeah. I don't use it with everybody, but I do use and it's really, the papers and data really support that it almost doubles the efficacy of each.

It's very hard to get. There's one compounding pharmacy in LA that you can get it from. But it's not so expensive, and the dose that we use it at for augmentation is pretty low, like, it is a relatively safe drug.

It's been around forever. Its old, its metabolized through the kidneys. But really it does seem to enhance the efficacy of each treatment. So then you can, instead of doing 40 treatments, you could do say 20 treatments.

And then a researcher named Sadiki did a lot of research about, like, the time between magnetic pulses and how much time the brain needs to recover in order for the next treatment to be effective.

And it's actually, with high-frequency treatments, about 30 minutes, and with low- frequency treatments it is about 50 minutes to an hour. And so if you look at it, if add deseglycerine and you do intermittent theta-burst TMS, you really can do it in one day or two days.

And the efficacy is… Very good. The durability is very good, it doesn't work right away, so there's usually a week, two week kind of period of time before people will start to see results, but So this is one of the issues, again, and it comes back circularly to the, I would say, irrationality of our healthcare delivery system.

But basically, no, it's not covered by insurance. So the same protocol is covered. By some insurances, like TRICARE, the VA, there's I think another two insurences that cover it.

I don't think the V. A. covers the It's very confusing and this is again where sort of like research and clinical experience have really outpaced policy and a lot of people even if they do use insurance to cover the traditional protocol, they require more than 36 sessions.

And the extra sessions are usually out of pocket and not covered by insurance. Accelerated TMS, I think, is this weird paradox of increasing accessibility because a lot of people can't do six weeks of treatment.

So, for example, college students could do an accelerated protocol when they're home for winter break or spring break. People who work or have a demanding job or small children could take two days off work and do it.

But it's not covered by insurance. And so part of developing the TMS portion of the business has also been trying to look at like financing options, sliding scale, how to make it feasible for people to access this as an option, as opposed to it being like just a straight concierge because then that makes it inaccessible to so many people.

Yeah. And healthcare, I believe this to be true as well. I mean, we're not treating conditions, were treating social

disparities. We're really treating injustices and the way people are living, and we are really not trading conditions.

Were really trading everything that brings on that condition in our environment. And I also agree with you that understanding the family, and often I see this too, this is a question, do you believe that the presentation that a teenager comes in, is it a presentation of something else too?

What's happening in the families? Or what kind of presentations have you seen? Yeah, for sure. to open your office? So I would say one of the more common, yeah, I'd say probably one the most common ones is whether implicit or explicit pressure from the family system that the child either achieve something academically or athletically or perform to some level, and the parents sort of not giving the child or young adult the room to differentiate, to internalize their own motivations for figuring out who they are in the world.

And even if that's different, if their values are different if, their goals are, different than their parents, parents being able to tolerate that and support that.

And so oftentimes when the kid comes in as the identified patient, but there's a lot of inflexibility in the in the system. And then another one I see very frequently is talking, I share my office with a developmental and behavioral pediatrician, and we were talking that oftentimes in families where there's one kid who has a medical issue or a development issue, or severe allergies or something growing up, the other sibling oftentimes ends up with a lot of internalizing symptoms because they had to not take up so much space.

And the the child who took up a lot of space with their externalizing symptoms or medical issues, then the sibling without that delay, like years later, a few years, later will sort of fall apart.

In your experience, who's bringing in the patient? Is it the adolescent coming in because they need help or is it a parent or somebody else referring to them?

I would say it's a mixed bag. the school pick up on it and recommend an evaluation. Sometimes, a lot of times though, it's coming from the adolescent or young adult, and a lots of time it is driven by social media.

I saw this TikTok about XYZ. I think I have that. A lot of school refusal. And then the parents or the school recommends we'll bring the kid in. What I find is that if an individual, whether they're an adolescent or young adult or an older adult, if they are forced into treatment, it's much less likely to be effective.

And if there's no buy-in, they don't want to there, or they see anything wrong with them, to me it is almost every time a waste of everyone's time and energy.

TMS Treatment and Access Challenges

And that is a very hard reality for a lot of families to face because it's an excruciating position for them to be in. But if the kid is not willing to engage, There's no magic dust.

Maybe they can find the right provider to crack in somewhere, but it can be really challenging if the parents are seeing that the kid needs help, that they kid is not willing to engage in care.

That's true. Well, let's talk a little bit. You mentioned suicidality, and this is something that we're seeing more and more of. The numbers have increased.

I mean, the number one death in adolescents and young adults is by suicide. And it never used to be as a number-one indication. high numbers of suicide rates.

More so than accidental death, more so then homicidal death. I mean, that should never be there anyways. So when a teenager or an adolescent or young adult has suicidal thoughts or has self-harm behaviors, what can parents do?

What are the concerns that shouldn't ever be dismissed? Yeah. It's a really good question, and it's complicated topic. And it reminds me, I recently had a conversation with somebody that we're living in such odd times where like longevity medicine and people having increased lifespans and like that dying until later is increasing.

And then younger people being like, all right, I'm done. I want to check out because they're hopeless about their future. They're homeless about ever feeling different or differently.

Their hopeless, about being able to get a job. There are hopeless. About having a voice. Um, they are. Hopeless about, um, being. Able to not feel like a failure.

because this system is set up, I think, where so many of them feel like they're climbing an impossible mountain. I tend to have a pretty broad range of being able to tolerate the discomfort and like provocativeness of self-harm and suicidality.

And so I always, I think it's very important for young adults and adolescents to be able talk about it because some of it is existential, right? Some of is like, what is the point?

Why am I here? I don't want to wake up and feel like this every day. I have meaning in my life. These are old questions that humans have been struggling with forever.

Maybe not forever, but of meaning and purpose. And that, to me, is very different than I have a plan to get a knife from the kitchen and kill myself. And I think the same thing goes with self-harm.

People self harm for lots of reasons that don't have to do with ending their life. They self harmed to feel something because they feel numb. they self harmed because They can't tolerate how anxious they are and that sort of stops how dysregulated they feel, they self-harm because seeing blood makes them feel real.

I have a lot of young adults and teenagers who describe feeling unreal, which I think is probably a symptom of technology. And so people self-harm, it's not always, is very provocative and scary for parents.

And I feel that, and I'm very sensitive to that. But I don't think it is always with intent to end one's life. I think a lot of times it serving a different purpose.

And so oftentimes I try to look at, okay, well, what purpose is it serving? And is there a way to get that need met without hurting your body? And so some of the work is working with parents to tolerate the distress of how provocative it is.

I find that the people who don't talk about it are the ones who worry me the most. Like if a kid is, if the teenager or young adult is talking about, I am much more reassured.

But if I get a spidey sense and then they're not talking about it at all, then I'm very, very worried. Yeah, the masking or the avoidance or denial of something that exists in hidden plain sight, something.

And people who end up killing themselves oftentimes don't talk about because they know what will happen if they talk And we're there in a double bind and we are in double-bind because of professional obligations and finding space to encourage people to be honest and open about what they're experiencing but also knowing that there are limitations to what you can hold it under kind of a professional ethics is really challenging.

Yeah, well, this has been a fascinating talk, and there's so many more questions I have. But I'm going to ask you, kind of condense some of those questions in a rapid fire.

We do this in the last part of our podcast, some rapid fires, just to give opportunity to all the questions that we have, in playful way, too. So answer whatever comes to mind, or if you want to say something more, I'd be happy to hear about that too.

Anxiety or depression, which is more often overlooked in teens? So I'm going to I think the distinction between anxiety and depression is completely artificial in some ways.

I am not a big fan of the DSM. siloing out anxiety from depression. Anybody who has experienced either will be able to usually articulate that they're deeply intertwined.

What is the biggest mental health myth parents believe to be true? I would say that their child's symptoms are solely located within the child. So I see a lot of families where they're a little resistant to therapy because there's this sort of idea that, oh, everyone's just gonna blame mom and dad.

And there is a resistance to seeing the child as unfolding within an environment. and that the child is born, that parents are not engineers of their kids, right?

The child was born with traits, hundreds and hundreds of genetically determined traits temperaments, aspects of the personality, and the parents cannot just mold the children to be how they parent actually doesn't have as big of an effect is they think that it has their, again, like presence, openness, connection, emotional, sustained connection is far more important.

Very, very true. What is the biggest mistake parents make when seeking help? I would say stay off of WebMD. Or chat GPT. There's a lot of bad information out there.

And again, I will say I'm not, over the years I've become less of a believer in kind of evidence-based protocols and algorithms, especially in children and teenagers, because I think our data sets are just so incomplete and we really haven't updated them so much.

So more medication is, more is not always better.

Family Systems, Suicidality, and Parent Guidance

And I think that there are many families where the parents or somebody they know has had a bad experience with a medication and then that taints their view on everything.

And so I tend to feel that like gold standard treatments, the SSRIs can be extraordinarily useful for certain individuals. But they're not totally benign.

They're safe, but they are not total benine. And that exploring, having other options, other choices, and other ways of looking at the experience. And having other ways for the young person to understand that they're not broken.

Like this idea of like, my brain is, this narrative of, like I have a chemical imbalance, My brain Is broken and I need to be on medication for The rest of my life.

I think is a huge misconception. And I would blame that more media and the pharmaceutical industry. Totally. My practice has moved more. I do more deprescribing now than I did five years ago.

SSRIs were never meant for people to be on them for 20 years. Yeah. I think I missed the boat on that because in my medical school, I learned about, you know, that eight, nine to 10, 12 months you did medication and you weaned and all.

And when I went overseas and came back I was like, wait a second, when did we stop, continue these medications and why are the children on four medications, five medications?

Yeah, yeah. And I think some of it again is like a desire to decrease the distress and discomfort of the family system. And so you treat, there's a pressure to treat symptomatically, right?

Like we have to get their sleep. and I talk to people all the time, sleep is not static, or sleep, yeah, it's not, static. It

never was meant to be static in human beings.

it changes with the seasons, It changes, with lunar phases, that changes the weather, changes barometric pressure, hormones, right, like there are all sorts of things and so you're not a machine, you are not supposed to sleep exactly the same every night.

And that's like a foreign concept, like as if we should just be able to click our fingers, go to sleep when we say so, and have it be consistent throughout the year.

It's human beings were not meant ever to asleep like that. And now I'm going to ask a very bold, dangerous question that relates to social media. What is your biggest concern about TikTok and mental health advice?

And just this question probably will screen us out of the algorithm because of TikTok. Totally. It's funny. I don't have TikTok, and I am actually like a self-proclaimed Luddite in a lot of ways.

I think that it's over determined. I there are many, many ways in which social media is is detrimental to the developing brain. And I think one is the attentional issues and this sort of, it's doing what it supposed to do.

It's hooking kids on quick dopamine hits and not slow dopamine experiences. So like learning a new skill, reading a book, having an interesting conversation with a friend.

Those are slow dopamine experiences that are going to be much more sustainable. I think that families have a very hard time limiting screen time and that things like not having phones at the dinner table, having them locked away at a certain time.

I mean, kids get really dysregulated around limitations. And at, at this same time, I think it's a double bind for parents because this is how kids, we can't escape it.

So I'm not I understand that it is a fact of modern life that we have to contend with. So I think the approach is not to necessarily cut it off entirely, but to really talk to kids continuously about what you're consuming, what accounts you are following, and what information you allow into your brain, what energies are you allowing into your brain?

Right? You can follow accounts that are about animals, if you're interested in our wildlife or the environment. And talking about sort of that you are, that kids have more control over and choice over what they let into their mental worlds.

But that it takes some conscientious effort and it take modeling from parents, right? Because if they see their parent Yeah, like yeah at the dinner table they're gonna Do the same thing?

Yeah so finish this sentence a mentally healthy teenager needs a Room to be imperfect. Oh, I love that. That's beautiful. I think, yeah, room to grow and be perfect.

Room be to imperfect, that just seals the deal on this talk. It really does bring a lot of this interior context, right? This idea of perfection, both that's visible in social media or what it appears to be or their expectations are from themselves and their parents and this idea perfection in not having this opportunity to learn and explore and make mistakes.

Exactly. And be messy and ultimately be like you are the only you that's ever been in the universe in this exact configuration and what that there's value and worth in that in and of itself.

Yeah. If a parent has to remember just one thing, it should be what? That their child does not have to earn love. But their child is worthy of love, attention, acceptance, no matter what.

Yeah, makes the biggest difference in outcomes, too, with that. Thank you for that, and I really appreciate being here this evening, doing this talk, particularly some of these, a little bit more to learn from you, I'm sure.

How would somebody contact you? What's your website? Yeah, my website for my private practice is sarahcishermd.com, I think. And then the TMS practice is sort of like getting up and running, and that's actually called Elysian T. M. S.

Center. And it has E-L-Y-S-I-A-N tmscenter.com because the t.m.s.

Rapid Fire Reflections and Closing

is under a separate business. And that offering is, I'm sort of in the midst of getting it out of beta and into… Well, just to learn more because we're doing TMS at our center and very interested in adolescent young adults as well.

And knowing that the marketing around the different machines is there to have cornered, you know, really taken over the market around that. And I think more education and more knowledge is needed in treating children with TMS, and I that's definitely a very promising, non-medicated way I also think neurofeedback is vital for what you described as on the phone, using the form of neuro feedback.

Exactly. It's a reinforcing. And TMS really is based on learning theory, like long-term potentiation, long term depression. I think Tms, especially the mobile options and the accelerated options, I there's very exciting research around dementia and around postpartum periods where it could allow women to get treatment that's not medication, that won't interfere with breastfeeding, um, That won' t separate mom and baby, and will also allow eyes in the home, which I think is so important in a post partum period.

So I think there's so much potential and there is more that we're learning every day and I it's a really exciting part of psychiatry that's developing.

Yeah, we'll stay in touch because I think this is an ongoing discussion for sure. Absolutely. We do have a platform called IOCAP. It's a adolescent and young adult care assisted provider group.

And I know you're a part of that. And I'd like to make that announcement for all the people listening, providers and therapists and clinicians who are treating adolescent and young adults, that there is hope.

There are ways, again, non-medicated ways as well as ways that you really look at root cause. You mentioned family systems and really, Delvin, we talked a lot about technology, the effect of technology.

And of course, this idea of development, and the effective development and other things can impact that both in a healthy and in an unhealthy way. So yeah, it's a great talk.

And there's more, I think, to be said about what's happening in the current environment of the new technologies and the research. Somehow, adolescents and pediatric patients always left out of that.

I hope that we can kind of continue and connect on ways that can really look at the outcomes on the special population. Yeah, absolutely. It was a pleasure and I appreciate being invited to talk.

And yeah, it was lovely to speak with you. Thank you Thanks for joining us on the Two Curious MD podcast. We hope today's episode inspired you to ask new questions and explore fresh perspectives.

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