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Titrating Social Media Use During Adolescent Inpatient Psychiatric Hospitalization

To the Editor:

Approximately 89% of adolescents have access to a smartphone, with 70% checking social media (eg, Snapchat, Instagram) multiple times per day.[1] Psychiatric hospitalizations for adolescents commonly involve suicidal crises with underlying interpersonal stressors, often inextricably embedded in the digital milieu. Upon psychiatric hospitalization, adolescents typically leave their smartphones with caregivers or in a locked area of the unit and enter into a social media "deprivation" period (inclusive of all digital social communication, such as texting). Generally, adolescents are reintroduced to smartphones after discharge. In many cases, they may be flooded with access to social media at this time, without the guidance of their clinical team. It is currently unclear to what extent absolute deprivation is helpful vs harmful for recovering youth. There are strong arguments for prohibiting digital media access, including the following: limiting exposure to online stressors (eg, cybervictimization) or inappropriate/risky content (eg, sexting, self-injury triggers), protecting patient privacy and safety, maintaining focus on treatment, and avoiding significant liability/logistical challenges (eg, monitoring use and information disseminated, ensuring that property is protected, ensuring equal access across patients, and need for knowledgeable staff). However, the aim of this letter is to consider potential *risks* of current norms of smartphone use within adolescent psychiatric hospitals. Preliminary clinical guidance and future research directions are outlined, with the goal of expanding precision medicine approaches to the reintroduction of social media to adolescents during and after psychiatric hospitalization.

CURRENT NORMS OF INPATIENT SOCIAL MEDIA USE: POTENTIAL RISKS TO CONSIDER

It is commonly accepted that social isolation is a risk factor for poor mental health, including suicidal ideation and behavior, in youth.[2] Removing adolescents' access to smartphones and social media when hospitalized may cause acute increases in loneliness and disconnection, despite increased access to potential unit-based peer supports. In line with 42 US Code 9501, the "Bill of Rights" for mental health patients, adolescent patients must be allowed to send and receive uncensored mail, and to use stationary unit phones to make confidential phone calls.[3] However, stationary phones are less relevant for today's youths, who are typically not socialized to talking over the phone. As a result, youths may be receiving less outside social support during hospitalization than they once did. The basic right to access telephone and mail communications may extend, at least in part, to social media. Indeed, many adolescents, including those admitted to psychiatric inpatient units, report that social media serves as a significant source of social support and connection[4]; this may be particularly true among gender and sexual minority adolescents.[5]

Beyond contributing to social isolation, preventing adolescent access to social media may represent a significant missed opportunity for inpatient treatment teams. With social media excluded from treatment entirely, hospitalized youth do not have the opportunity to learn and practice using social media in healthier ways under clinical supervision. Instead, after discharge, adolescents may experience postdischarge "flooding" of smartphone access. This may be harmful for emotionally vulnerable youth, who may be forced to suddenly confront an array of peer stressors. Adolescents' disappearance from the social media landscape is likely to be noticed by their social network, potentially sparking rumors and anxiety over whether to disclose their hospitalization to peers. Moreover, some adolescents may have posted publicly regarding suicidal ideation or plans, and are thus faced with confronting the fallout upon discharge.

PRELIMINARY CLINICAL RECOMMENDATIONS AND FUTURE RESEARCH DIRECTIONS

Research is needed to better inform clinical practice regarding digital media use during hospitalization. Given the notable clinical, safety, and privacy concerns motivating the prohibition of smartphone use during hospitalization, we do not propose unregulated use. Yet, for some adolescents, it may be appropriate to re-introduce social media access before discharge in a monitored and regulated fashion. In these cases, we believe that the same provisions should apply to regulated use as are applied to the use of the telephone. Like all treatment

TABLE 1 Clinical Recommendations for Smartphone and Social Media Use During Psychiatric Hospitalization and Key Questions for Future Research

Preliminary clinical recommendations	Key questions for future research
• Increase screening and assessment of: o Typical daily smartphone use o Personal benefits and risks of social media use o History of any problematic social media use o Any concerns related to recent social media activity o Coping skills for negative online experiences	• What are the current practices, policies, and norms regarding digital media use on adolescent inpatient units? • How effective are current social media use policies in regard to adolescent recovery during and following inpatient hospitalization? • How do patient outcomes compare across inpatient units with different smartphone policies (ie, monitored social media access allowed vs. prohibited)?
• Consider re-introducing smartphone/social media access *before* discharge in a monitored and regulated fashion for certain adolescents • Decisions should be made on a case-by-case basis, in which risk and benefits of smartphone access are carefully weighed • Consider introductory psychoeducation groups for all patients and parents, outlining appropriate smartphone use and limits • Parent, adolescent, and treatment team should make decisions collaboratively • Including families in social media–related therapeutic work may help to enhance parent-adolescent communication about social media stressors after discharge	• How feasible and acceptable are the proposed digital media use policies for inpatient units? • How can key stakeholders be engaged (ie, inpatient clinical staff, patients, parents, hospital administrators) to ensure appropriate policy making for inpatient units? • What standardized set of factors should be considered when determining whether an adolescent should be given smartphone access during inpatient hospitalization? • To what degree should parents be involved in decision making regarding mobile device use for individual adolescents during inpatient hospitalization?
• Example smartphone skills to be taught: o Balancing smartphone use with other activities (eg, in-person interaction, exercise, academics, sleep) o Individualized change plans for social media use after discharge o Online social skills: managing negative interactions and cybervictimization, appropriately eliciting social support o How to block, filter, and report inappropriate users and content o Cognitive techniques for maladaptive thought patterns related to social media (eg, social comparison, fear of missing out) o Digital safety and citizenship skills o Problem solving skills related to social media o Establishing safe and appropriate sexual and romantic boundaries online o Establishing general healthy boundaries on social media platforms (using exemplar of communicating reasons for absence from school)	• What skills should be included in psychoeducation programs around healthy smartphone use? • Which adolescents benefit most from learning which smartphone skills to promote recovery? • What factors may influence the efficacy of inpatient smartphone introduction and psychoeducation programs? o For example, interpersonal experiences during admission and after discharge (interpersonal stress, social support), patient smartphone use history, clinical presentation • What outcomes should be considered in evaluating the efficacy of such programs? o For example, clinical course (length of stay, readmission rates, symptom severity), clinical factors immediately before/after social media titration (PRN use, mood/anxiety symptoms, problematic behaviors)
• Examples of integrating smartphone use on unit: o Individual or group sessions (cameras may be covered with tape), focused on practicing healthy social media skills in vivo o Family meetings focused on social media problem-solving skills and setting healthy limits on use; developing collaborative Family Media Use Plan (www.healthychildren.org/MediaUsePlan) o Discharge meeting in which teens identify social media–related triggers and/or coping strategies to facilitate recovery, and creation of a Safety Plan, which may be stored on the phone	• Does inpatient programming to support healthy digital media use lead to subsequent improvement in media use and clinical outcomes? • Which programs are most effective and for whom?
• Given rapid changes in social media platforms, clinical staff should receive semi-regular primers on current social media trends and related impacts	• How can hospital systems provide effective, up-to-date training for clinical staff on media use policies?

decisions access to digital communication should be decided for each adolescent individually by carefully weighing potential risks and benefits. We propose that for some youths, regular limited and supervised access during hospitalization could facilitate social media skill learning and in vivo practice, in addition to therapeutically beneficial social support (Table 1). Monitored re-introduction, with associated limit-setting, might be helpful to actively expose adolescents to potential social media stressors *before* discharge; in turn, youths would have the opportunity to receive support and guidance in problem solving any stress-inducing issues safely, while under clinical observation. Given the dearth of empirical literature on this topic, however, research is sorely needed to best inform adolescent inpatient policies (Table 1).

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Accepted June 23, 2020.

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Dr. Burke was supported by the National Institute of Mental Health (NIMH) T32 grant MH019927. Dr. Nesi was supported by the American Foundation for Suicide Prevention (AFSP; PDF-010517). Any opinions, findings, and conclusions or recommendations expressed in this material are solely the responsibility of the authors and do not necessarily represent the views of the AFSP.

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Disclosure: Dr. Romanowicz has received grant funding from the Mayo Foundation Departmental Small Grant Program and the Palix Foundation. Dr. Croarkin has received research grant support from NIMH, the ,Brain and Behavior Research Foundation and Pfizer, Inc.; equipment support from Neuronetics, Inc.; and has received supplies and genotyping services from Assurex Health, Inc. for investigator-initiated studies. He is the primary investigator for a multicenter study funded by Neuronetics, Inc. and a site primary investigator for a study funded by NeoSync, Inc. He has served as a consultant for Procter and Gamble Company and Myriad Neuroscience. Drs. Burke, Nesi, and Domoff have reported no biomedical financial interests or potential conflicts of interest.

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0890-8567/$36.00/Published by Elsevier Inc. on behalf of the American Academy of Child and Adolescent Psychiatry.

https://doi.org/10.1016/j.jaac.2020.06.008