Mental health communication skills for child and adolescent primary care

Reference manual to accompany Bassett/Johns Hopkins training program

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Introduction and how to use this manual:

Thank you for taking part in this training program. This brief manual is meant to serve as a back-up and elaboration to specific topics that we will talk about together in our training sessions. It was not intended to be read cover-to-cover. We have tried to organize the manual so that you can use the index to turn directly to pages describing particular skills or situations. We also hope that you will find it useful for "self-study" as you review recordings of your own visits, or when you think about situations that come up in your day-to-day work.

One clarification we want to point out from the start: we use the word "provider" to indicate nurse practitioners, physicians' assistants, and physicians, all of whom may be seeing patients for primary care.

What is our teaching philosophy?

We welcome feedback on the contents of this manual. All material is presented with the understanding that primary care providers don't do 50-minute therapy hours; all the techniques described are meant to be used in the context of day-to-day primary care visits. Thus this manual contains a menu of maneuvers that clinicians can use as they find necessary. We expect that experienced providers will find some of the techniques useful but perhaps find parts that don't apply well to their practice style or to their practice setting.

We also recognize that all of us have different areas of expertise and skill; we hope that those who initially feel more comfortable with this material will be able to convey their experiences and knowledge to those who are less comfortable. We also hope that those who are less comfortable will have much to contribute from their own areas of comfort. We see the training process as one of mutual learning where we all have much to teach each other.

Finally, we recognize that new skills are not learned overnight or always remembered in the middle of hectic days. The clinicians and researchers who have developed much of this material remind us that the 'spirit' of the method is what is most important. That is, that we can be most effective by collaborating with patients and guiding them toward their own goals, insights and motivation as opposed to always trying to be one step ahead in our formulation or by being too quick to offer advice based on the way we see things (Rollnick 1999).

Background and rationale

About 15 percent of school age children and adolescents in the US are thought to have an emotional or behavioral disorder (Lahey et al, 1996; Costello 1989). Nearly two-thirds of those who are depressed receive no formal mental health care, and only half receive counseling or some other form of assistance at school (Wu et al, 1999). To provide more care for this group of young people requires several strategies, including reducing stigma and financial barriers, educating young people and their families about the benefits of seeking care, and increasing the availability of effective services in accessible settings (National Advisory Council, 2001).

One way of broadening access and reducing both financial and psychological barriers involves promoting the detection - and in some cases treatment - of mental health problems by primary care providers. Primary care providers, in fact, already provide the bulk of mental health services to adults and children in the United States (Wang et al, 2000). Primary care visits offer many potential advantages for helping families with mental health problems. Primary care's philosophy of promoting and tracking healthy development fits well with the task of preventing and monitoring for emerging mental health issues. Longitudinal relationships have the potential to build trust and willingness to share sensitive issues. Long-term relationships also mean that mental health care can be delivered episodically as needed, in a familiar setting, and in the context of care for medical issues.

However, many young people (and their parents) don't disclose their emotional problems to their primary care providers (Horwitz 1998). Parent and provider assessments of child mental health frequently do not agree (Murphy 1998), and its is estimated that families follow through with only about 40% of the mental health referrals made by primary care clinicians (Kelleher 2001). These difficulties aren't surprising when one considers the challenges posed by how pediatric primary care is structured. Visits are relatively short, and there are many competing concerns to be addressed. If problems are found, referral sources may be limited, and pediatric providers report low levels of confidence in managing mental health problems themselves (Olson 2001).

We chose the skills in this manual to address three main goals. We hope that the skills will help pediatric primary care providers:

1. efficiently uncover and clarify mental health needs
2. have therapeutic encounters with people who are demoralized or angry
3. give advice about mental health problems (including making referrals) that will be accepted and followed

The skills that we present offer an approach to clinical interactions that contrasts with the style of most routine medical encounters. The traditional pediatric style is energetic and directive. It assumes that patients and their families come with questions and needs (of which they may not always be aware), and that the providers job is to offer specific advice and advocate for its acceptance. This approach works much of the time, especially for situations where there are few emotional overlays. However, it can fail when people are ambivalent, ashamed, anxious, or feel their freedom is being challenged. In those situations, patients don't always admit what really concerns them, and they may resist the advice that is offered. Despite its feeling of efficiency,

this approach can be time consuming when it leads to medical work-ups for psychosomatic complaints, or to multiple interventions that consistently miss the mark. It can also lead to families dropping out of care.

An alternative style is what has been called "patient centered" or "quiet and curious" (Stewart 1995, Miller 1991). In this approach, clinicians provide a setting where patient concerns can be expressed, where patients take the lead in developing goals and the strategies to attain them, and where information is offered in response to patients' expressed needs. This approach is specifically designed for situations with strong emotional overlays where ambivalence, demoralization, and anger get in the way of patients being able to use the advice clinicians offer. It can be an efficient method for helping people institute change in their lives, and it helps clinicians and patients work together during times when change isn't yet possible. Most importantly, however, taking this approach does *not* mean that we don' t offer advice, or don't have strong feelings about what is the right thing to do. But our advice is well-timed, comes after a conscious effort to elicit the patient's point of view, and is clear and from the heart but not pushy.

The clinical goals – what might you accomplish in a 10 to 15 minute visit

Our approach assumes that, in the long run, clinicians want to make accurate diagnoses and initiate appropriate treatments. However, mental health problems often come up unexpectedly or in the course of otherwise busy days. In that case, initial goals usually don't include making a diagnosis but do include:

1. **Ruling out medical, social or psychiatric emergencies**
2. **Providing immediate relief in the form of a therapeutic encounter, and provision of specific (to the patient's problems) but generic (with regard to diagnoses) advice**
3. **Developing a mutually agreeable plan for further evaluation and, eventually, treatment based on a provisional differential diagnosis**
4. **Preventing patient emotions and concerns from disrupting a reasonable process of clinical evaluation and treatment planning (that is, staying in control of the visit and balancing the needs of this patient with the needs of other patients who require care)**
5. **If you work in a setting with limited mental health resources, buying time to read or seek consultation so that you can manage aspects of the problem yourself.**

By the end of 10-15 minutes:
No, we don't really think that this is an optimal length for any visit, and hopefully you have more time. But we do think that envisioning this short time period is helpful to overcoming the notion that potential mental health problems are automatically a threat to your sanity and that of your workplace. What we present here are four goals that we believe can be accomplished in a short time; following each we list briefly some skills that we think will help you accomplish the goals. The skills are taught in our training sessions. We also describe them and give examples in this manual.

1. Patient/parent will feel reassured that their problems have been accurately described, "make sense," and can be helped in some way.

Essential skills: Opportunity given to disclose full range of concerns, including safety issues; clinician and patient/parent come to agreement on description of most important concerns (clinician thus able to offer more specific and credible reassurance, advice).

Use open-ended questions and ask about psychosocial issues even for established patients.

Actively involve all parties to the visit; actively assure that all get a chance to contribute to agenda-setting.

Ability to tactfully redirect conversation when it rambles through summarizing, making lists, asking for priorities.

Other useful skills:
Eliciting and reframing or normalizing the story so that it "makes sense"

2. Patient and parent levels of stress, distress, conflict will be reduced, at least temporarily.

Essential skills: Clinician can effectively deal with negative emotions and with conflict among family members during the visit. Use of turn taking and redirecting negative statements. Reinterpreting negative feelings as concern, offering empathy for people who are angry or hurt.

Asking speakers to rephrase statements that propose negative generalizations or attribute behavior to negative traits.

Promptly address "ruptures" in relationship with patient/parent: apologize for mis-cues.

3. Patient/parent will leave with at least one thing that they can do to make the problem better in the short term (behavior plan, referral, medication, repeat visit, emergency or crisis intervention, etc.). These often include "non-specific" interventions aimed at symptoms (for example, interpersonal problems, parenting issues, sleep or eating issues) pending a more specific diagnosis.

Essential skill: Clinician deals with requests for advice in a way that takes into account patient/parent's stage of willingness to take action, concerns about barriers, and attitudes toward particular actions. Clinicians elicit patient/parent's ideas about actions and present lists of options incorporating patient/parent's ideas rather than single "prescription."

If advice is not requested overtly by patient/parent, clinician asks for permission to give it, offers choices, frames advice in general terms ("some people might") rather than saying "you should." Always present choices, if possible incorporating positions the patient has already stated.

If patient/parent feel unsure or hopeless that actions can help: Quantifying confidence action can be taken. Asking what would improve confidence a bit.

Identifying exceptions to problems.

Making vague goals into specifics that can be measured and achieved in small steps.

If patient/parent is ambivalent or rejecting of advice: "Roll with resistance" rather than confront it. Ask people to clarify the importance of the problem and ask what would increase importance.

Explore pros and cons of action.

Ask for permission to give more information or advice, and solicit their reaction to what you have said.

Acknowledge anger over coercive situations and tactfully distance yourself from them,

offer choices.

Elicit larger goals and *ask* tactfully how current behavior (or rejection of advice) fits with goals.

4. Patient/parent and clinician agree on steps that will be taken to develop a differential diagnosis and longer-term treatment plan (repeat visit, results of referral, etc.).

Essential and useful skills: same as (3).

Concerns

There are at least two concerns that might be raised about taking this approach. First, it seems to contrast with usual pediatric practice in its willingness to accept uncertainty of diagnosis. On reflection, though, in many pediatric encounters, a specific diagnosis can't be made at the outset, but we do offer some immediate help and develop a plan to understand what is happening. For example, we are frequently not sure if a child's ear pain really represents recurrent otitis, but we can start a plan of treatment and monitoring designed to provide relief and ultimately understand the cause. We propose that providers can become equally comfortable helping a family with what may be a case of ADHD or depression, even if the diagnosis is not clear at the outset. The skills we present are designed to help the provider "make a difference" while things get sorted out.

Second, are our four goals compatible with the "SOAP" approach to medical assessment? We say emphatically "yes." As we see it, SOAP (subjective information, objective information, assessment, plan) represents the clinician's internal thought process of making an evidence-based assessment and developing a plan that logically follows from the assessment. Our four goals describe an interactional framework for SOAP so that patients and families can take an active role in each step, and thus, hopefully, be maximally invested in carrying out the "plan."

The skills

1.Efficiently eliciting the full agenda and settling on a topic for today

a. background and rationale: Many if not most patients never tell their doctor their full list of concerns (Horwitz, Barsky). Two prominent ways in which this happens are a) patients often don't give their main concern first, and doctors interrupt and take over the discussion before the main concern is divulged, and b) that patients give lead-ins or hints, but doctors frequently ignore them and move on to other topics (Levinson).

Why might patients be so hesitant to speak up?

- people can be ambivalent about even very distressing situations. One thing they may fear in particular is losing control of the situation -- if I admit I have a problem, someone will tell me what to do about it. There is evidence, for example, that some patients don't tell doctors that they are depressed because they are afraid that the doctor will pressure them into taking a medication (Rost 1998).

- people may feel ashamed or embarrassed about a situation, and fear that disclosing it will either be inappropriate or bring a disparaging response.

b. getting the full range of concerns

1. Setting up the environment for disclosure: despite being busy and knowing that this is a short visit, show your interest and attention through good eye contact, not fussing with the chart, closing the door, etc. Try through your manner to show that you have the time to listen.

2. Open-ended greeting -- "How have things been since the last time?" "How can I be of help?" rather than, "So I see we are here for shots today."

3. Trying not to interrupt the patient's initial answer by asking specific questions or giving information. Show your interest in having them continue: either nonverbally, by briefly summarizing what they have said so far, or by asking if they can "help me see the whole picture" or "tell me more about what they have noticed about the problem." Often all that is needed is a pause of a few seconds and people will begin to elaborate on what they have been saying.

4. Not ignoring "hints."
   Doctor: "How have you been since last time?"
   Patient: "Well, I guess OK."
   Doctor: "You don't sound too enthusiastic. What has been happening?"

5. Asking if there is "anything else?" until there are no additions to the list. Important concerns -- or more information about what came earlier -- often comes at the end.

Note: patients sometimes hold back elaborating on their concerns out of a fear that they will bias your assessment. "I don't want to influence what you think too much." You may need to explicitly say that you want to hear everything that they think might be relevant.

c. setting the agenda.

1. Sometimes it seems obvious that the multiple concerns raised by a patient all relate to a single underlying issue. You can speculate on this, check for the patient's agreement, and then ask which aspect is the most troubling or with which they would like to start.

   "You've raised several things related to how he is doing in school -- paying attention in class, sitting still, doing his homework. Is there one of these that you see as most important at this point? Perhaps we should start by thinking about that."

2. If there are several concerns and their relationship is not clear, play back the list and your impression of what seems to be the most important:

   "You've mentioned several things but it seems that your worry about his staying out late is what concerns you the most, is that right? Maybe that is what we should focus on today." Or, if a priority is not clear, "You've mentioned several concerns -- which ones did you want to make sure we talked about today?"

d. what if people ramble?

1. gently interrupt, paraphrase, and ask for additional concerns: "I'm sorry to interrupt, but so that we don't run out of time, let me see if I understand your concern.... [paraphrase, get confirmation]. OK, good, now was there anything else that concerned you?"

2. gently interrupt, paraphrase, and refocus: "I think I understand what you are talking about. You started by talking about [some original issue]. So we don't run out of time, do you want to get back to that, or do you want to talk about [the new/tangential issue] now?"

e. what if the child or a partner is there, too?

1. make a connection with each person present: a specific greeting for each, a handshake if appropriate; while talking, shift eye contact and body position to address everyone; get everyone's name if you are not sure; use their name when you address them.

2. develop the visit agenda from talking to all parties, not just the parent. Invite each to add to the list or validate the priorities. "Is that what is most important to you, too?"

"Do you have anything else that you want to bring up?"

3.if there is disagreement at this stage:

- point out areas of agreement: "I hear you both saying that relationships in the family are important, but you (teen) are concerned about being respected by your parents and you (parent) are concerned about how much time he spends at home. Do you think there is a common thread to those things that we could talk about?"

- normalize disagreement: "I can tell you are all/both very concerned/care a lot about each other, and I admire/respect you for that."

- reassure that ultimately you can make opportunities for discussion of everyone's concerns. "We might only be able to get at one of those things today, but I want to make sure that I write down what you are saying so that we can be sure to talk about it the next time we meet."

2.When people seem to be asking for advice

a. background and rationale: Even when people seem to be clearly stating a concern or even directly asking for advice, it is not always the case that they are likely to accept suggestions made in response. Both patients and providers play a role here (Rollnick 1999):

- patients may not be ready to take action, even when they are quite concerned about something. They may not see the problem as that important, they may see equally strong reasons *not* to act, or they may have little confidence in their ability to make a change.

- even patients who are very ready to change may feel cornered, challenged, shamed, or otherwise dis-empowered by well intentioned clinicians whose advice is formulaic, or that seems to come with a label that they are not ready to assume.

- people generally are more likely to act when they develop their own motivation to do so, rather than when they feel that they are being pushed or actively persuaded.

Advice has to be tailored to where individuals are in their readiness to make a change, to their confidence that they can do it, and to their particular goals and values. Although providing advice this way is not nearly as complicated as it sounds (and is not necessarily any more time consuming than straightforward advice offering), it does require:

- taking the time to understand how people define a problem, what they see as the relative importance of addressing it now, and how confident they are that they can make a change.

- being able to offer appropriate information in a neutral, supportive way.

- being able to offer (or consider) a range of possible approaches to the problem.

- not pushing people to act before they express a willingness to do so (though this does not mean taking a passive approach to their action or inaction).

b. responding to direct requests for advice: rather than just quickly starting to respond with your thoughts:

1. clarify goals: "Let me make sure that I know just what it is that we want to be getting to..."

2. assess readiness to act: "I know that this is something that you want to act on, but tell me first a little bit about what has brought you to want to act on it now." "How confident do you feel that you can make the changes now?" Important: the tone of these questions is not challenging, implying doubt, or seeming to be some sort of test. You are curious, your purpose is to best tailor your advice -- you can say that as an introduction.

3. assess any potential barriers or misgivings: "Is there anything that makes you worry that this might not be the time to act (or that you shouldn't do anything about this problem)? "Is there anything that makes you concerned that you may not be able to make the changes?" Try to deal with these problems actively -- for example, finding telephone numbers or offering to call yourself to set up an appointment.

4. get some idea about what they have been thinking: "I am happy to give you some ideas, but first I wonder what sorts of things you have been thinking about?"

5. offer advice as tentative choices that others have tried: "I don't know how you would feel about any of these things, but some people have found it helpful to do...., and sometimes other people have found that ... is helpful. I wonder what you think about any of those things?"

6.try to make the advice you do offer as specific and practical as possible.

3.When people seem ambivalent about acting on a problem

a. background and rationale: Sometimes ambivalence is obvious -- someone tells you that they can't make up their mind about how they feel or what they want to do. Sometimes you can only read it in someone's expression as you start to offer advice to them. You have three goals in these situations: a) to avoid turning ambivalence into resistance, b) to get permission to provide information that may help resolve the ambivalence, and c) to turn ambivalence into a decision to act.

b. techniques for helping with ambivalence

1.the "elicit-provide-elicit" model (Rollnick 1999, p111) is a way of getting permission to give information that might help people decide (and thus avoiding a "lecture" that can result in further ambivalence or even resistance).

- *elicit* a request for information: "You mentioned that you were worried about his mood but were not a real fan of counselors or of medicines. Would you like to hear some thoughts about those things, and maybe some other options?"

- *provide* information in a neutral way, keeping it simple and slow-paced.

- *elicit* a response: "What do you make of that? Does any of that make sense to you?" Be ready to either elaborate, provide more information, or to agree that this is something to think about for another time.

2.quantify importance and confidence (Rollnick 1999, p79). Ask people to rate, on a scale of 0-10, the importance of an issue and/or their confidence in their ability to address it. These exercises have several goals: they help elicit "self-affirming" statements about resolve and confidence, and help people define for themselves factors that would motivate them to act. They also generate numbers that can be used as benchmarks for further discussion.

- if the number is low but not zero (that is, low importance or confidence), ask, "That is not a lot, but what are the things that make it not zero?" "What would have to happen to increase the importance/confidence up a couple of points?"

- if the number is relatively high (that is, high importance or confidence), ask, "Why is it so high?" How could you move it up even higher? What stops you from moving up higher?"

3.examine the pros and cons (Rollnick 1999m p81). This exercise may develop information similar to quantifying. People are asked to think about (you can jot down a 2x2 table as they talk), the pros and cons (or potential benefits and costs) of leaving a problem as it is and the pros and cons of making an effort to change. What is important is that *this is not meant to induce some simple weighing of the good and bad*. That is, the goal is not to have

a teen say that on the whole, smoking looks good because it makes her social interactions go better, so she will not attempt to quit. The goal is for the clinician to be able to empathize with the dilemma faced by the patient. "Well, I can see why this is a difficult decision for you: smoking makes it easier to socialize and you are afraid that if you stop you will gain weight, but at the same time you recognize that it is not good for your health. Now that you have thought all this out, where does it leave you now? Does it leave you with any new ideas or questions?"

4.When people seem unaware of a problem

a. background and rationale: Sometimes you, the clinician, feel someone has a "problem" but they don't. An example might be a parent who uses physical punishment to an extent that you feel is unproductive. Your goal is to help the person identify *for themselves* reasons why they might want to recognize the issue as a problem; you know that if you approach it head on with a "prescription" that your advice is likely to be rejected (or heard politely but ignored).

b. techniques for starting a discussion

- Ask, "In what way has the spanking created problems for you?" (Miller, p82) (Note: the question is asked with the tacit assumption that it has caused some problem; the word 'if' is not used.) If the patient answers, try to amplify it with "What else have you noticed?" Respond neutrally, perhaps contrasting these problems with the benefits the parent has previously mentioned. "So on the one hand you feel that spanking helps with his behavior, but your wife gets upset when you do it and things stay unsettled between the two of you for a while." Don't be afraid to just leave this hanging (see below, "develop discrepancy").

- Use the "elicit-provide-elicit" model mentioned above to ask if they would like some more information about the subject. "You mentioned that sometimes you use spanking to get her to behave. That's an area that people have a lot of thoughts about -- would you like to hear some more about it?"

- Develop "discrepancy." What this means is to gently and respectfully point out how current behaviors contrast with stated goals and values, and how objective markers of behavior contrast with those goals. Note that this is different from warnings and negative predictions. These comments are always framed a speculations on your part, not as confrontations:

  - "I remember you telling me that you would like to be a lawyer when you grow up. I was wondering how that fits with the kind of grades you are getting now?" Or "You have talked about how important it is to feel respected; it seems like your friends might not respect you when they see how you behave when you drink. Can you tell me a little more about how respect works among your friends?" Contrast these with: "You will never get into college if you keep getting grades like this."

5.when advice seems to be rejected overtly or subtly

a. background and rationale: How do you know your advice is being rejected? Patients may overtly argue with you, become defensive, deny or minimize problems, or simply ignore what you are saying. (Miller p 103). Why might this happen? The traditional view of resistance in patients is that it reflects lack of motivation, personality issues, or a lack of insight and intelligence. While all of these may play some role, clinicians' behaviors also play a part. In particular, individuals may become resistant:

1. as a defense against feeling ashamed of their current or past behavior
2. if they feel that they are being coerced, cornered, or rushed
3. if they are being urged to do something before they are ready to do it
4. if they don't want to lose "face" in front of another family member who is in the room with you

b. Various means of "rolling with resistance" (Miller). Though we have often been taught to confront resistance (and probably have seen many of our teachers do it), for the most part confrontation results only in a hardening of opposition. Instead, try:

1. reflect the thought back. "So you have heard some bad things about Ritalin." Quite often people will then come back to you with a statement that offers some kind of opening. They may go into detail about their concern, giving you an opportunity to show respect for their position, provide information, and understand parameters that might form an alternative plan. They may become a bit more conciliatory, revealing that they do, in fact, see both sides of the issue. That also opens a possible path to a workable solution.

2. shift the focus. "Whoa! I can see that you know a lot/have thought a lot about this, but you are way ahead of me. We still need to understand the problem better and lay out all the possible things we could do."

3. agree with a "twist." "You are right -- medicines certainly can be a problem if they are not used carefully. The cases you have heard about where children had problems -- do you know anything about the dose they were using or how they were checking for side effects?"

4. emphasize choice. "There are many ways to approach this problems -- my job is to help you get the information you need to deal with it." "I am sorry if I got ahead of where you were thinking. Where are we now? It is perfectly fine to put this issue aside until you feel that you have all the information that you need."

5. make sure there are not other constraints of which you are not aware -- in particular, other family members who need to be consulted. "Before we talk more about this, is there anyone else who you would like to have here/who you would like to be able to talk to before you decide?"

6. don't be afraid to drop the subject. "I am sorry. I didn't mean to touch on something that you felt so strongly about. Would you rather that we just drop it for today? There are lots of other things we could discuss, and I don't want that to come between us."

6.**when a parent or child feels they have been coerced into coming**.

a. background and rationale: Children and teens frequently tell you that it was not their idea to come to the doctor for a particular problem. Parents, sometimes, have been told by an agency, school, or court that they must see you for counseling or medication. You often can empathize with patients and families in this situation, and it is sometimes tempting to do so in a way that puts down the referring source: "The school people think every kid needs Ritalin." "The social service people seem to refer everyone whether they need it or not." Though these statements may contain a grain of truth from your perspective, they can undermine the legitimacy of the whole therapeutic system, including your part in it. Perhaps worse, they reenforce the patient or family's role as a victim, which ultimately is not helpful. An alternative goal is to start a process through which the patient or family can again start to feel a sense of control. This process can be seen as having three stages: acknowledging anger, distancing yourself tactfully from the coercive referral, and offering choice (Rollnick 1999, p129).

b. building an alliance with an involuntary patient

1.acknowledging their anger: "I would probably be angry, too, if I felt that someone was telling me what to do that way. I know that I can't make anyone do anything they don't want to do."

2.distancing yourself from the potentially coercive force, without putting it down. "The schools know a lot about kids and classroom behavior, so I respect their concern, but I am your doctor and my first responsibility is to you."

3.Offer choice and promote a sense of control: "Let's first take a good, broad look at the situation and decide what you think is best to do. I will be glad to talk to the school and explain to them whatever we decide." "I realize that it wasn't your idea to come, but I am really interested in hearing how you feel about this issue." "Would you want to talk to me alone now or with your mother here?" "I guess it is doubly hard getting told you have to talk to someone and then not even having the choice of who that is. Do you think you might feel more comfortable with someone else? I can help you set that up if you would like."

7."But I don't know that much about counseling" for depression/anxiety/behavior problems - helping people who feel helpless or frustrated

a. background and rationale: Certainly, the more you know about specific mental health problems, the better. Precise diagnosis is ultimately important, and it is essential to ask at least briefly about both suicidality and abuse whenever patients voice emotional and behavioral concerns (Frankenfield 2000). On the other hand, many of the emotional and behavior problems that appear in primary care involve mixtures of symptoms that cross diagnostic categories and may not meet formal criteria for being a "disorder" (DSM-PC). In these situations, what is often most important, as a first step, is understanding the specific feelings and situations for which people want help. You can then go a long way toward relieving low mood, anxiety, and other problems by giving hope. Hope comes in two forms: people's knowledge that you have heard and empathize with their concerns, and the help you have given them in formulating a plan of action.

Anger, low mood and anxiety cause a "tunnel vision" that makes it hard to see a way out of problems; hopelessness and demoralization become vicious circles (Elliot 2002). Focusing on goals for the future, and how to get there, can initially be more productive than a detailed analysis of how problems came about; sometimes it is all that is needed. "Solution-focused" therapy grew out of a need for ways to help people in the course of brief interactions (Walter 1992, Klar 1995).

Solution-focused interactions have the following characteristics:

-Hopelessness is relieved through several mechanisms:

i. By identifying and building on strengths and past successes; people can come to feel confident and competent rather than demoralized and helpless
ii. By "re-framing" events and feelings so that negative attributions about oneself can be made positive or at least neutral
iii. Distant and diffuse goals are broken down into small, concrete steps that are more readily accomplished

-solution focused interactions look at observable behavior that either leads to or is part of a desired goal. This is in comparison to focusing on stopping an undesired behavior, or on having poorly observable things like "attitude" as goals.

-The patient is considered to be the expert on both desired goals and on ways to get there; the clinician is a facilitator and coach. What follows from this is that it is the patient - often through telling you the "story" of the problem, who provides the outlines of the solution. Helping the patient formulate this story is a key piece of the treatment.

b. solution-focused techniques

1.elicit and re-frame the story. First, elicit the "story." By "story" we mean the patient's understanding of how they came to be in a particular situation. Although at first many people will say that they don't know, a prompt can be to just describe when the problem started and how it has evolved. "I know that we could probably talk about this for hours, but in a few minutes, starting at the beginning, tell how you got to this point."

The first and often the only re-framing technique necessary is your ability to play the story back in a way that provides validation and empathy. In order to change, people need to feel understood and supported. You don't have to agree with everything the patient did, but you can support the difficulty of the situation, and point out how the problems they are describing actually "make sense" given the circumstances in which they find themselves. "So here you are, a single parent trying to hold down two jobs, with a child who is not the easiest in the world to manage. Then on top of that, your own mother gets sick and needs you. What a tough situation." Always pause a bit here so that the patient/family has a chance to make corrections or to elaborate on what you have said. Don't worry if they tell you that you "got it wrong." Your paraphrase is just a vehicle to get them thinking - their corrections are a sign that they are engaged in the process.

A second re-framing technique is to look for situations that seem "big" to you but which seem to be glossed over in the patient/family's account. For example, a parent told you the story of progressive difficulties with a child's behavior, and quickly mentioned in the middle of the account is the fact that his/her own parent died during that time. In your playing back of the story, you note this and speculate that it must have had an impact. "So in the middle of all these difficulties with the school, you lose your own mother. That must have made things particularly hard." Again, be ready to be corrected or even contradicted. You may get recognition that it was, in fact, a big deal that has been glossed over and the parent may start to cry. Alternatively, you may be told that the elderly parent had been ill for a long time and the death was a relief. What matters is that in this exchange there is both clarification for the patient and shared understanding between you and the patient.

A third re-framing technique you can use when listening to stories is to observe and comment on "shoulds." "Shoulds" can be stated explicitly, as in "whenever he does X , I have to do Y," as regrets, "I should have done?" or implicitly through a pattern of behavior that recurs in a story (Allmond 1999). "So you are saying that every time he gets into trouble it is your job to bail him out. That sounds like an important rule that you are following - where did it come from?" Note that in your comment you are not suggesting that the rule is bad, or even suggesting an alternative point of view. But by asking someone if this really is a "rule" that they follow, and asking them to comment on its origin, you give them the opportunity and permission to make a modification. "Well, it seems like good parents are always there for their children, but I guess that I have also heard that sometimes you just have to let them learn from their mistakes."

Eliciting stories usually segues into "so where do we go from here?" or "so what do you want to have happen next?"

2. setting goals. Concrete goals serve many functions. They provide a guideline for getting to a desired place, and they provide a way of measuring how far along one is to getting there, and they provide a sense of movement and accomplishment. In general, useful goals have the following characteristics:

-people develop them for themselves

-they are framed in terms of behaviors that are observable and that constitute desired activities (versus goals that represent feelings or attitudes, or that state decreases in undesired activities). For example, if a parent starts out saying that she would like her teenage daughter to stop being so negative in her responses to requests, a corresponding quantifiable goal might be that that the daughter will initiate the requested activity within a certain time and with no more than one prompt.

-They are often framed in very small steps - what is the first change in that direction that you would like to see?

-They can be counted and thus progress can be assessed.

3.When someone is "stuck" and cannot see a way out of their problems. A first level of questions can be:

-What will people be doing differently once the problem is better? This is sometimes phrased as "the miracle question." "If you woke up tomorrow and by some miracle you didn't feel so depressed, what would you then do differently? Could you do just a little bit of that now, even though you still feel depressed?"

-What would be the first, small sign that things are beginning to improve (Klar 1995, p134)?

-What would help you move up a point or two in your confidence that you can fix this problem? (see above)

If someone continues to be "stuck":

-go through an example of the problem situation in detail, looking at the sequence of events that leads up to it and trying to identify places where a behavior or response might be changed. An alternative is to ask the family to describe a "typical day" in which the problem occurs. Sometimes doing this requires giving a family "homework": "If it is ok with you, how about taking a week to write down every time he does X, including exactly what you were doing when it happened." This assignment can be given to a family after a telephone consultation as preparation for an office visit. (Note that this technique can also be used for anxiety problems - what thoughts go through your head at those

moments, and what can you tell yourself instead?)

-look for exceptions in the past: "I am guessing that there are sometimes when he does what you ask him - what do you do at those times to make it work? Can you try doing that more often?"

-Helping people see things as both/and situations rather than either/or (Lipchik 1992): "How do you think you could set some limits on his behavior but at the same time show him that you respect his intelligence and his ability to make good decisions?"

8.**More about engaging both children and parents** (includes managing conflicted discussions)

a. background and rationale: In pediatric visits, doctors typically spend most of their time talking with parents. Doctors tend to collect information from children, but then give deliver their formulation and advice mostly to the parent (van Dulmen 1998). Parents are more satisfied, children learn more, and outcomes may be improved, when doctors give information to both parents and children (Lewis 1991). In addition, children and parents provide contrasting information about many problems -- parents report more overt behavior problems than children, but they tend to lack knowledge of children's mood problems and underestimate the extent to which children have been exposed to stresses outside the home (MacLeod 1999, Richters 1993) .

b. techniques to try. At several earlier points in this "manual" we have talked about ways of managing interactions with more than one "patient" in the room. We recap some of them here and add some specific items about engaging children.

1. When a visit begins, attempt to individually greet and acknowledge each person in the room.

2. Using age-appropriate language and taking your time, try to elicit both initial concerns and follow-up information from children as well as adults.

3. Do your best to keep the conversation balanced between parent and child. You can do this informally by shifting your gaze and body position back and forth. If you sense the need, state explicitly that you want to hear from everyone.

    - "I want to make sure that you both get a chance to talk about things as you see them. Which of you would like to go first?"

    - If one party interrupts: "I want to make sure that we have time to hear both of your views -- can you hold that for just a minute while X finishes?"

4. When there are disagreements:

    - don't get "in the middle" or take sides -- ask parent and child or parent and partner to address each other rather than talking to you as if the other was not present. "It may seem a little funny, but rather than telling me about X, can you tell X yourself how you feel about things?"

    - if people are upset with each other, first find something positive in it, but then try to tone things down. "This must be hard -- it's difficult when two people care a lot about each other but really disagree. Is there a way you could tell X how you feel but also let him know how much you care about him?"

    - be on the alert for statements that cast another family member as all good or all bad, or imply that the speaker knows just what someone else is thinking.

Examples include: "He is always late/he never picks up after himself." "He is lazy/he doesn't care about anyone else in the family." Responses on your part can be:

> "Ever, never, always -- those words have a way of putting people on the defensive. Can you try telling her those concerns again, but without using those words?" (Allmond p35).
>
> "People often get upset if they feel you are labeling them -- and it can really stick with kids even if they tell you they don't care. Can you tell him what he does that upsets you, without using that label to explain why he does it?"
>
> "This may seem a little silly, but could you try to start every thing you say with 'I think' or 'I feel' so that she will know that it is your opinion and something that we can talk about?"

5. Engage children as much as possible in developing and trouble-shooting treatment plans. Use language they can understand -- filling in more details for the parent as needed. When you develop a treatment plan, ask children to walk through it with you and see what part they want to play. Ask them to give you feedback on specific parts - make a note of those things in the chart and ask about it at subsequent visits (Lewis 1991). For example:

> "So it seems that you and your mom agree that we should try to medicine to see if it can help you do better in school. That's going to mean taking a pill every morning. How are you at taking pills? Are you good at remembering things? Do you have any ideas about how we should do that? Next time, can you tell me how that plan you had for remembering worked out?"

9.Promoting a longitudinal alliance

a. background and rationale: Longitudinal relationships have the potential to build strong bonds between clinicians and patients (Stewart 1995). These bonds facilitate change and make it easier to share sensitive information. Just being together repeatedly over time, however, doesn't necessarily create good working relationships (Wissow 2002). Research suggests that a) what happens at early visits is very important -- patients develop assumptions about their role that subsequently are hard to change; b) even when relationships start off well, trust and willingness to spontaneously disclose problems are slow to develop.

b. techniques to try:

1.Actively promoting the ongoing relationship: research suggests that it is important to keep inquiring about feelings and problems, and to keep encouraging patients to take an active role in visit. One can't assume that familiarity breeds willingness to share.
- "So what has been happening with you since the last time we met?"
- "I remember that you told me about difficulties you were having with your job -- how did that turn out?"

2.Responding to patient/family concerns: not surprisingly, how you responded to a kind of problem in the past influences how likely someone is to bring up that sort of problem again.

- don't knowingly ignore or give short shrift to a problem that a patient or parent expresses. Even if you can't deal with it now, acknowledge it and make some sort of an arrangement to help.

- avoid situations where you and the patient both end up hopeless. This often happens when the patient is already feeling frustrated and/or if the problem if complicated. Rather than starting to fire off a list of possible things to do (which tend to be sequentially rejected until you run out), substitute curiosity and brainstorm (see above).

- keep the tone of your advice and your compliments relatively neutral: being too hearty or seeming too authoritarian may also discourage disclosure of problems.

3.Dealing with "ruptures" in the relationship: disagreements or misunderstandings are inevitable in any close relationship. We inevitably put our feet in our mouths by failing to remember a name, saying something that turns out to be insensitive, or by causing a patient the inconvenience of waiting too long. Though it is nice to avoid these situations, they offer opportunities to cement relationships and to demonstrate to patients how repair of problem relationships in their own lives may be possible.

- apologize

- empathize with the discontent or anger

- be a good listener -- hear the criticism or explanation, and acknowledge what you have heard

- express your wish to have it not happen again, thank the patient for raising the issue, and assure them of your interest in getting feedback in the future.

A mini-library for mental health skills in pediatric primary care

Two books that address many of the communication techniques we describe, but in much more detail:

Rollnick S, Mason P, Butler C. Health behavior change: a guide for practitioners. Edinburgh, Churchill Livingstone, 1999. This book is aimed at general medical practitioners (the examples are mostly from adult care), but its goal is to help practitioners influence patient behaviors in the course of routine visits.

Allmond BW Jr., Tanner JL, Gofman HF. The family is the patient: using family interviews in children's medical care. 2nd edition. Baltimore, Williams & Wilkins, 1999. This book is very much aimed at pediatricians -- it includes material on using family therapy principles and techniques in day-to-day practice and in special family sessions.

Two books can be helpful with responses to specific clinical problems:

Parker S., Zuckerman B. Behavioral and developmental pediatrics: a handbook for primary care. Boston: Little, Brown and Co., 1995. This paperback book is larger than a pocket manual but organized that way -- 89 short chapters give key questions for diagnosis, succinct treatment guidelines, and some additional references. Some suggestions about pharmacologic treatments need updating.

The Diagnostic and Statistical Manual for Primary Care (DSM-PC): Child and Adolescent Version. Elk Grove Village: American Academy of Pediatrics, 1999. This version of the standard psychiatric diagnostic scheme, DSM-IV, functions as a diagnostic guide rather than a treatment manual. One particularly helpful and original feature helps clinicians grade the severity of issues into three broad categories (developmental variations, problems, and disorders). This can be very useful for deciding how to conceptualize a problem and for deciding the level of consultation or treatment that might be appropriate. Does not include treatment guidelines.

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Using the "four goals" model for concerns about hyperactivity, distractability, or inability to stay on task in school

1. **Patient/parent feel reassured that problem has been accurately described, "makes sense," and can be helped in some way.**

- Ask about person/situation originating concern; ask parent and child if they concur.

- Get a good description of the problem noting presence or absence of ADHD criteria in *mulitple settings and over time*.

Inattention:

fail to pay attention to details or making careless mistakes
trouble sustaining attention or avoiding tasks that require it or that don't give immediate feedback
not listening
not following through
trouble being organized, losing things, forgetful

(***note: in the absence of hyperactivity (especially girls), these children may be seen as sluggish, drowsy, spacey, or withdrawn)

Hyperactivity

fidgeting
being out of seat
running or climbing excessively
difficulty playing quietly
always on the go or driven
talking excessively

Impulsivity -- trouble in rule-governed situations

blurting out answers
difficulty awaiting turn
interrupting or intruding on others

- Listen for other possible issues: low mood, anxiety, history of trauma, learning problems.

- Understand urgency of situation as perceived by parent and child, understand their expectations for this visit (including concerns/expectations about using medicine).

- Get an idea of the "one worst thing" or problem that needs to be addressed acutely.

2. Reduce patient and parent levels of stress, distress, conflict.

- Be attentive to negative labels, blaming, and other talk that you can address in the visit.

- Make child active participant in discussion.

- Note your ability to be advocate if necessary.

3. **Patient/parent leave with at least one thing that they can do to make the problem better in the short term.**

- Elicit patient/parent ideas about what would help problem identified as the most important or "one worst thing." Give simple, clear behavioral advice aimed at a small, attainable improvement. Ask about potential barriers and implementation issues; modify advice accordingly. Possibilities often include:

  a. giving advice about organizing time or homework (making lists of tasks, calendars, providing space free of distractions, suggestions for parental monitoring)

  b. instructing parent in ways to give clear, one-step directions with quick follow-up for understanding and compliance
  - give fair warning about need for upcoming action ("In a few minutes we will…")
  - offer options when possible ("Would you like to do you homework before or after?")
  - be clear about when there will be consequences ("I will ask you one more time and after that you won't be able to watch TV tonight)

  c. avoiding "set-up" situations where child's problem is a particular vulnerability

4. **Patient/parent and clinician agree on steps that will be taken to develop a differential diagnosis and longer-term treatment plan.**

- Review differential diagnosis and elicit agreement on need to explore prior to developing treatment.

Consider:

a. give Connors or other rating forms for home and school; consider phone call to school if feasible
b. ask for report cards or other means of screening for learning problems
c. give out any appropriate literature
d. set up return visit to discuss results/options/evolving differential diagnosis

Using the "four goals" model for concerns about low mood (including sad, angry, irritable)

1. **Patient/parent feel reassured that problem has been accurately described, "makes sense," and can be helped in some way.**

- Ask about person/situation originating concern; ask parent and child if they concur in concern.

- Get a good description of the problem. Try to get an idea of when it started and if there seem to be any precipitating factors. In listening to story, think about presence of:

  1. depressed mood or irritability most of the day, nearly every day, by personal report or outside observer
  2. marked loss of interest or pleasure in all or most activities most of the day, nearly every day
  3. marked increase or decrease in appetite
  4. insomnia or hypersomnia
  5. psychomotor agitation or retardation nearly every day
  6. fatigue or loss of energy
  7. excessive guilt or feelings of worthlessness
  8. problems with concentration
  9. recurrent thoughts of death or suicide - *****always ask specifically about suicidal thoughts**
     frequency and content of thoughts
     access to means of killing self
     how patient weighs pros and cons of doing it
     social supports
     models/relatives/friends who have suicided or attempted

- When listening to the story, consider as possible simultaneous or alternative diagnoses:

  Anxiety problems: worry or fears are more salient than low mood
  -Post-traumatic problems: traumatic event followed by nightmares, flashbacks, ongoing worry and startle responses, avoidance
  -Ongoing exposure to violence or trauma
  -Obsessive-compulsive problems: worries about cleanliness, handwashing, other intrusive thoughts
  -Substance problems: history of use, intoxicated appearance
  -Bereavement: "normal" course thought to be under 2 months.

- Probe for and get consensus on how this has had an impact on function at home, school, with friends.

- Understand urgency of situation as perceived by parent and child, understand their expectations for this visit (including concerns/expectations about using medicine).

- Get an idea of the "one worst thing" or problem that needs to be addressed acutely.

2. **Reduce patient and parent levels of stress, distress, conflict.**

- Explain need for careful evaluation and availability of multiple treatment options.
- Be attentive to negative labels, blaming, and other talk that you can address in the visit.
- Make child active participant in discussion – many young people will need the opportunity to speak with you alone.
- Empathize; express support; normalize, express optimism while recognizing difficulty of feelings.

3. **Patient/parent leave with at least one thing that they can do to make the problem better in the short term.**

If any concern for suicidality suggest immediate further evaluation by social work, psychology, etc. If this is not possible, arrange for safe, comfortable place to wait while you make arrangments to spend more time in evaluation or arranging referral.

- Elicit patient/parent ideas about what would help problem identified as the most important or "one worst thing." Give simple, clear behavioral advice aimed at a small, attainable improvement. Ask about potential barriers and implementation issues; modify advice accordingly. Possibilities include:

  a. reducing any acute stresses including work overload, while maintaining reasonably busy level of activity to avoid brooding "down time."
  b. developing a "mantra" that addresses a prominent, recurring negative cognition mentioned in the history (for example, "I always fail" could be countered by "I am a good big brother" or similar). Parent affirms this and will re-enforce.
  c. normalizing sleep schedule.
  d. prescribing pleasurable activity.
  e. asking parent if their own mood/stress is currently an issue and how they might also be able to ease up (explain that moods can be "contagious")

4. **Patient/parent and clinician agree on steps that will be taken to develop a differential diagnosis and longer-term treatment plan.**

- Review differential diagnosis and elicit agreement on level of severity, appropriate time frame for seeking additional information or treatment, kinds of treatment that child and parent would consider.

Consider:

a. return visit with child, parent, other parent/family member to collect further information.

b. permission to contact school counselor or other professional already involved with child.
c. referral to specialized mental health professional for evaluation and/or treatment
d. give out any appropriate literature
e. set up return visit to discuss results/options/evolving differential diagnosis
f. review means of emergency access if suicidality appears

Using the "four goals" model for concerns about anxiety problems

1. **Patient/parent feel reassured that problem has been accurately described, "makes sense," and can be helped in some way.**

- Ask about person/situation originating concern; ask parent and child if they concur.

- Get a good description of the problem. Try to get an idea of when it started and if there seem to be any precipitating factors. In listening to story, think about presence of:

  1.medical triggers: asthma, thyroid conditions, hypoglycemia, medication or substance reactions
  2. panic attacks – sudden episodes of palpitations, shortness of breath, tremor, sweats
  3. specific situational triggers to the anxiety (all can be with or without panic attacks)
     performance or exposure to unfamiliar people or scrutiny in public: social phobia
        public speaking
        talking to strangers
        using public bathroom
        eating in front of others
     specific phobia
        animals
        nature: heights, storms, weather
        blood and shots
        types of injuries
        situations (planes, elevators, bridges)
     fear of separation from home or major attachment figure
        school avoidance
        worry about health of parent
  4. OCD: most common obsessions are contamination, doubts (with need to check), desire for ordering, fear of aggressive or horrific impulses, sexual images; most common compulsions: handwashing, checking, mental operations like counting or having to repeat a phrase or song
  5. PTSD: was there a specific, highly traumatic event?
     rexperiencing - reactions to cues, sense of reliving, dreams, reactivity to cues
     arousal - startles, change in sleep
     avoidance - numbing, trouble with recall
  6. Associated with a variety of events or situations: generalized anxiety
     pervasive anxiety and worry
     often motor symptoms including trembling, dry mouth, nail biting

- When listening to the story, consider depression, ongoing exposure to violence or threat (child abuse, domestic violence).

- Probe for and get consensus on how this has had an impact on function at home, school, with friends.

- Understand urgency of situation as perceived by parent and child, understand their expectations for this visit (including concerns/expectations about using medicine).

- Get an idea of the "one worst thing" or problem that needs to be addressed acutely.

2. **Reduce patient and parent levels of stress, distress, conflict.**

- Explain need for careful evaluation and availability of multiple treatment options.

- Be attentive to negative labels, blaming, and other talk that you can address in the visit. Make child active participant in discussion – see separately if necessary.

- Empathize with feelings; express support; express optimism while recognizing difficulty of feelings.

3. **Patient/parent leave with at least one thing that they can do to make the problem better in the short term.**

If any concern for child abuse, assault, or suicidality suggest immediate further evaluation by social work, psychology, etc. If this is not possible, arrange for safe, comfortable place to wait while you make arrangments to spend more time in evaluation or arranging referral. If concern about domestic violence, ask parent if you can speak to them alone.

- Elicit patient/parent ideas about what would help problem identified as the most important or "one worst thing." Give simple, clear behavioral advice aimed at a small, attainable improvement. Ask about potential barriers and implementation issues; modify advice accordingly. Possibilities determined by the type of anxiety but may include:

  a. reducing any acute stresses including work overload, while maintaining reasonably busy level of activity to avoid brooding "down time."
  b. developing a plan to approach a specific fear (eg. bedtime, going to school)
  c. asking parent if their own anxiety is currently an issue and how they might also be able to communicate confidence to child.

4. **Patient/parent and clinician agree on steps that will be taken to develop a differential diagnosis and longer-term treatment plan.**

- Review differential diagnosis and elicit agreement on level of severity, appropriate time frame for seeking additional information or treatment, kinds of

treatment that child and parent would consider.

Consider:

a. return visit with child, parent, other parent/family member to collect further information.
b. permission to contact school counselor or other professional already involved with child.
c. referral to specialized mental health professional for evaluation and/or treatment
d. give out any appropriate literature
e. set up return visit to discuss results/options/evolving differential diagnosis

Using the "four goals" model for concerns about somatic problems

1. **Patient/parent feel reassured that problem has been accurately described, "makes sense," and can be helped in some way.**

-Concerns are usually long-standing and patient/parent may have had the experience of prior clinicians minimizing importance (though this may have been technically true); thus important to listen with empathetic but neutral stance

--Try to go beyond the symptoms in eliciting the history – what was happening at the time of onset or recurrence, what other issues are happening now, what areas of functioning are affected and which are spared (ie, school impaired, social function not, or vice versa).

-Probably will be necessary to use skills for staying in control of time: state available time frame at outset, along with desire to fully understand. As patient/parent to prioritize and discuss what is most important to them. Assure that further discussion will be possible. Summarize to clarify your understanding.

-As you listen, consider diagnostic categories (adapted from DSM-PC).

Questions to help sort somatoform disorder categories:

a.are multiple organ systems involved?
b.are the lab tests normal or, in contrast, particularly hard to explain?
c.have there been recent particularly stressful life events
d.is there a long history of stressful events (abuse, separations, losses)
e.is there a model in the environment
f.is there a family history of somatization or affective disorder
g.what might be being gained (for patient or family) by persistence of symptoms
h.is there a history of multiple prior consultations or what might prove to be "doctor shopping?"

Could it be a medical condition? (think also about co-occurrence of medical issues and emotional distress)

a. well-defined but hard to diagnose conditions that present early with vague symptoms: SLE, MS, occult tumors, psychomotor seizures, thyroid disease, myasthenia gravis, migraine, anemia, sleep apnea and sleep phase disorders, chronic sinusitis, EB , ulcer disease, inflamatory bowel disease.
b.controversial syndromes: chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, tension headaches, atypical chest pain, hypoglycemia, allergy-tension-fatigue, RSD
c. substance use/abuse?
d.side effects of medications?

What other mental disorder could it be or might also be a part of the problem?

1. major depression (with or without delusional beliefs), especially in some cultures; depression thought to be an element in as many as half of all somatoform disorders
2. panic disorder or other anxiety disorders with panic symptoms (chest pain, SOB, tingling)
3. hallucinations/delusions as part of psychotic disorder
4. OCD
5. sexual abuse (frequently presents with chronic abdominal, pelvic pain)
6. Munchasen syndrome by proxy

Is it predominantly a single neurologic symptom (motor or sensory, except pain or sexual dysfunction): consider a diagnosis of **conversion disorder**

a. involves voluntary motor function (for example, paralysis of an arm) or sensory problem

b. onset often after a stressful event or conflict, or an injury to that part of the body
c. no evidence of conscious intent to cause it
d. not a result of an identifiable medical condition or a culturally sanctioned behavior or experience
e. onset usually from ages 10-35; not as likely before or after
f. usually acute onset
g. more frequent in women than men (at least among adults)

Is the main problem worry about having a particular disease or diseases (versus having a symptom)?
consider **hypochondriasis**
a. if the concern is for contamination in general, and involves a need to wash frequently, consider obsessive-compulsive disorder

Is the main problem preoccupation with body appearance (**body dysmorphic disorder**)
a. fear that one looks funny to people
b. fear that a particular blemish or difference is noticed by all
c. can involve multiple body parts
d. not part of eating disorder (where sole issue is that one is too fat)
e. often starts in adolescence but not revealed till later

Are there multiple unexplained physical symptoms
a. undifferentiated somatoform disorder
    1. fewer than the **8 or more** specific complaints that are required to be labeled somatization disorder
    2. high prevalence of ultimately having other mental or medical disorder
    3. prevalence of this among kids may be pretty high - 10-15%; probably peaks in late childhood, early adolescence (at least the pediatric variety, though as get more symptoms see it more commonly in adolescents)
b. **somatization disorder**
    1. 8 or more symptoms (over time – not necessarily all at once)
    four pain symptoms - four sites or functions
    two GI symptoms other than pain (nausea, vomiting, diarrhea)
    one sexual symptom other than pain (dysfunction, indifference, excessive menses)
    one neurologic symptom other than pain (motor, sensory, LOC, amnesia)
    2. onset before age 30; often cumulative number of symptoms starting in adolescence
    3. symptoms often wax and wane around identifiable stresses
    4. usually not a lot of insight into possible emotional component
    5. often strong family history

Is there a concern the symptoms could be intentionally produced
a. malingering – feigned or self-induced illness to achieve some goal other than just sick role
b. factitious disorder – patient attempting to assume the sick role
c. Munchausen Syndrome by Proxy – parent or adult falsifies or inflicts problem on child
    1. persistent or recurrent problems that stump clinicians or suggest rare conditions
    2. child's overall function contrasts with severity of symptoms or laboratory findings
    3. symptoms never occur and/or signs do not appear when medical personnel present
    4. difficulties obtaining details or records of prior evaluations or treatment
    5. history of multiple invasive tests or treatments (often with considerable morbidity that seems worse than purported problem)
    6. often evidence of symbiotic bond between one parent and child, excluding others
    7. parent may have history of medical training

2. **Reduce patient and parent levels of stress, distress, conflict.**

- brief but credible physical examination focused on symptoms and safety (Gask).

- probe for range of opinions within family as to cause/nature of child's problems or appropriateness of evaluation; validate differences, empathize with frustration, seek common points of view

- propose developing consensus goals of evaluation/treatment plan

- acknowledge and empathize with the pain or other problem, but when appropriate introduce a specific physiologic link between the symptom and stress or other emotional state (example: when people are anxious, their brain is in "fight or flight mode" and that sends signals to shut down the stomach – that can cause pain.) (Gask)

3. **Patient/parent leave with at least one thing that they can do to make the problem better in the short term.**

If concern for child abuse, assault, or suicidality suggest immediate further evaluation by social work, psychology, etc. Note that suspected Munchausen Syndrome by Proxy may be one situation where prematurely sharing concerns with family is thought by some to represent a threat to the child's safety.

- initial "assignments" can include gathering records and making logs of symptom occurrence; focus on exceptions – times that symptoms have been less or functioning better. Brainstorm about what mechanisms this waxing and waning might suggest.

- identify areas where functional status could be improved and suggest definite (though small) return toward normal function. Example: if child has been allowed to get out of some physical activity, suggest graded return.

- help family develop rewards for resuming more normal role, find ways to minimize possible gain from assuming sick role.

- schedule return visit to hear more of story, especially information from other evaluations or from concerned family members who are not present initially

4. **Patient/parent and clinician agree on steps that will be taken to develop a differential diagnosis and longer-term treatment plan.**

- suggest regular, brief visits to head off unplanned visits with new concerns or exacerbations; keep this up especially when symptoms seem to wane.

- when timing seems right, propose mental health referral; not as primary treatment for symptoms but to help with stressors that have been identified.