

Initial Approaches to Addressing Behavioral & Emotional Concerns in Primary Care

Module 1 – Brief Intervention

Rationale

This module uses 2 case vignettes, reflective exercises, and group discussion to educate residents about the need to integrate mental health care into the medical home and to engage residents in applying the information presented to a clinical situation.

Goal

Utilize evidence-based approaches to engage patients and families in managing mental health concerns.

Objectives

1. Explain the importance of addressing mental health concerns in children and adolescents and the rationale for doing so in primary care.
2. Discuss strategies to integrate mental health into primary care for each stage of a child's emotional development.
3. Summarize the importance of establishing alliance (physician-patient-family) as a platform for providing mental health care in the medical home.
4. Practice incorporating the common factors approach as a tool for facilitating communication with families about mental health concerns and other pediatric issues.

Materials Needed

1. Background handout: The Rationale for Addressing Pediatric Mental Health Concerns in the Medical Home
2. Pre-conference reflective exercise
3. Tool: Generic or Common Factors Interventions (HELP)
4. Tool: Mental Health Screening and Assessment Tools for Primary Care*
5. PowerPoint presentation: Module 1 – Brief Intervention. This facilitator's guide provides points for preceptors to highlight.
6. Role play materials
7. Post-conference reflective exercises

Time

- Pre-conference reflective exercise should take residents 10 to 15 minutes to complete before conference. This should be followed by reviewing the handout on *The Rationale for Addressing Pediatric Mental Health Concerns in the Medical Home*.
- Presentation, role plays, and facilitated discussion could last anywhere from 15 to 45 minutes, depending on how much discussion occurs with the group. Where to implement this module depends on time constraints—this could be a continuity clinic talk. This could also be given during a morning report or noon conference.
- Post-conference reflective exercise can be completed immediately after the PowerPoint presentation or at the end of conference that day. You may want to think about asking residents at the end of their session to go through each of their visits and think about what types of health promotion, anticipatory guidance, and screening tools they could incorporate into the visits from that day.

Preparing to Facilitate Module

1. Review reflective exercise
2. Review and duplicate handout
3. Review PowerPoint presentation, case vignettes, and role play materials
4. Review facilitation/discussion suggestions for indicated slides
5. Encourage residents to share their thoughts and reflections at each step

Implementation Options

Role plays have been created in order to make this module more interactive and fun. The initial case with Dennis can be a role play to set the stage at the beginning of the module. A mother, child, and physician would be needed. Please see materials for role play instructions.

After the initial case is shown on the PowerPoint slide or via a role play, facilitators may consider asking for a volunteer to play the role of the resident and present the case to the faculty preceptor. In addition, the facilitator can divide the group into groups of 2 or 3, with one as the resident presenting the case of Dennis to the other participant acting as the preceptor. If a 3rd participant is present they can be the observer taking notes on the interaction. Provide each participant with a copy of their role and allow them to review the scenario and role for 2 to 3 minutes. Time-outs can be called by role-players and the facilitator. The person for calling the "time out" should state why he/she asked for a break. The first person to provide thoughts should be the resident playing the physician role. The facilitator can ask the physician to reflect on how the scenario is going then request insights from the other role play participants and any observers. Participants can change roles and re-do the scenario or pick up where the first person left off. The facilitator could consider playing the physician role in order to save time and model important questions that should have been asked about school and Dennis' behavior. Another option is that facilitators can train their faculty to use these teaching modules using role plays after this initial scene.

Slide 21 demonstrates questions that should be asked. A detailed history about the behavior in question is needed. What is the antecedent? What is happening in Dennis' environment before he begins to fight? What is the actual fighting behavior he demonstrates? What happens afterwards? What is his past medical history, developmental history, behavioral history? What is his temperament like? How does he adjust to new situations? How does he interact with you or other members of the family? How do you discipline him? Are there any new psychosocial triggers? Trauma? Divorce? What is his environment like? Is the neighborhood safe? Is there scary television on at home?

After presenting Module 1: Part 2 on common factors, role play #3 can occur. The preceptor would go into the room with the mother with the resident present. The preceptor would again conduct the visit using elements of common factors. Observers could be taking notes on which aspects of common factors were used during the interaction.

* The AAP does not endorse a specific screening tool. Instead, the AAP provides a list of several tools to avoid bias. The facilitator is free to select a tool from this chart and print out copies for residents to review.

Facilitation Points to Consider

Slide 1: *Title Slide*

Slide 2: *Case #1: Dennis*

This case is meant to activate learners through their experiences. The setting is the continuity clinic. You may read the case off the slide, or choose to present the case via role play in front of the group. Two to three volunteers are needed to play the role of mom, resident, and Dennis. See role play instructions.

You are conducting a well-child visit for a 6-year-old male you have seen once before, Dennis. You ask where Dennis is attending 1st grade and his mother immediately becomes distressed.

She tells you he has previously been “kicked out” of 2 classrooms for fighting. In the exam room she frequently criticizes Dennis as she relays the history of his problems and periodically gives orders to him in an angry tone of voice.

Before moving to slide 3 you also have an option to do role play #2 where the resident presents the case to the preceptor. This is a good option for introducing the curriculum to other faculty members.

Slide 3: *Case #1: Dennis*

Stimulate residents in thinking about patients they have seen in clinic by asking the following questions:

- Have you seen a child like this before?
 - If so what did you do?
- What could be going on with this patient?
- Do you think this common?

Encourage residents to share their experiences with patients in their patient panels that may have presented with behavioral or mental health concerns.

Slide 4: *Goals & Objectives*

Review the goal and objectives of the session.

Slide 5: *Leading Causes of Limitation*

This slide is meant to demonstrate how mental, developmental, and behavioral health concerns have become more prevalent and surpassed physical illnesses in prevalence for disabilities in pediatric patients.

Slide 6: *Barriers to Care for Children With Mental Health Concerns*

This slide is purposely left blank to stimulate conversations about barriers residents may have had with the patients they mentioned earlier.

Was there discomfort in the residents' ability to care for these children? If not discussed previously, do residents believe there are barriers to caring for children with mental health concerns? Is time a barrier? Is a lack of resources a barrier?

Slide 7: *Barriers to Care for Children With Mental Health Concerns*

At this point you can give the handout on statistics of pediatric mental health issues if not already provided before the session.

This slide highlights some statistics about pediatric mental health disorders and some barriers. There are other statistics that were included in their background handout that residents may point out or that you may wish to include. This is also a list of barriers—most of these were also in the handout residents could have referred to prior to coming to this session—or a handout given at the session.

Slide 8: *The “Primary Care Advantage”*

This slide highlights the rationale for why general pediatricians are well suited to care for pediatric mental health concerns.

Talking points from the literature can include: Pediatricians offer a setting that encourages trusting, longitudinal relationships with the child and family. Beginning in infancy, pediatricians can nurture resilience; identify adverse childhood experiences and other risks to healthy psychosocial development; screen routinely for emerging symptoms and for problems in child or family functioning; and intervene when risks, concerns, or symptoms arise. The skills necessary to identify and address undifferentiated psychosocial problems and emerging symptoms are fundamental to pediatric practice.

Slide 9: *Mental Health in the Medical Home*

At this point the preceptor can pause and ask residents what role they think pediatricians should play in pediatric mental health care, if this has not been done already.

Slide 10: *Mental Health in the Medical Home*

This slide gives an overview of how mental health care can be integrated into the medical home. The suggested talking points are below.

- Mental health can be compromised at many critical times in development.
- Therefore, pediatricians need to promote mental health in activities aimed at prevention, risk assessment, and diagnosis to offer an array of appropriate interventions, including possibly making a referral or co-managing with a mental health professional.
- Sometimes it is useful to compare mental health illnesses to physical illnesses so that residents can understand that the same process pertains to both. For instance, for asthma, pediatricians routinely ask about secondhand smoke, family history of atopy, and other environmental exposures early on to prevent and/or anticipate atopy in infancy. This should also be done with mental health. Pediatricians should ask early on about a family history of mental health or substance abuse disorders, mom's support system, safety at home, and parents' knowledge and feelings about parenting. After a first time wheeze, some pediatricians would consider pulmonary function tests or give counseling as to what to look for in terms of repeat episodes. If a behavioral concern comes up, this should be discussed, counseling should occur, and at times screening tools can be used.

Slide 11: *Review of Dennis' First Year of Life*

Now let's go back to Dennis. The facilitator can discuss how the resident looked back through a colleague's notes to further understand Dennis' behavior. This slide discusses how he presented with behavioral concerns during early infancy.

Slide 12: *Identifying Mental Health Concerns in Primary Care: Early Infancy*

This chart shows us the stages of emotional development in infancy, how to promote and prevent problems in the primary care office, and how to identify challenges early on. Parents' ability to respond appropriately is determined by their own life stresses, their past experiences with other children, their knowledge, and the fit between the temperaments of the child and parent.

- At this point in a child's emotional development, promotion and prevention of challenges to a child's emotional development should include watching the caregiver and infant interact. It is very important to obtain a family mental health history during the first few visits so targeted anticipatory guidance could be offered for high-risk children. Psychosocial screens can be used here. Questions about domestic violence, housing instability, neighborhood violence, divorce, and substance abuse are important to assess the psychosocial environment. Pediatricians should observe interactions in the exam room and ask caregivers as to whether their child looks at them, smiles, and whether they are able to console or comfort their child. As the infant gets older, the pediatrician can observe how attentive the parent is and whether they are able to comfort the child.

- Questions about behavior could include

- "What do you and your partner enjoy most about your baby?"
- "What is challenging about caring for your baby?"

Questions about how the parents are feeling is important. Anticipatory guidance should include encouragement for maternal self-care. Separation anxiety occurs during this time period and pediatricians can reassure parents that this is a normal part of healthy behavioral development.

- Anticipatory guidance can be given to enhance development of secure attachment. The AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* specifically suggests that providers stress the importance of self-care for parents or caregivers. Encourage parents to understand their baby's temperament and how they process the world so they can better respond to his needs and fussy behaviors. Encouraging a consistent, predictable, and daily routine for infants can help them learn how to manage their own behavior as they get older. Guidance on discipline can be provided. Remind caregivers to model behavior they expect their child to learn. Promote discipline that encourages distractions, is consistent, and limits the amount of times "no" is stated.
- Screening for caregiver depression and/or other psychosocial risk factors should be done during these early months.
- A referral to a mental health professional can be beneficial to further evaluate discordance between parent and child temperament or difficulties with parent-infant attachment.
- A mental health professional can provide individual treatment for parents with depression as well as parent-child dyadic therapy.

Resources exist in *Bright Futures* that guide observations in the exam room.

www.brightfutures.org/mentalhealth/pdf/professionals/in/observation.pdf

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Slide 13: *Symptoms in Infancy of Challenges to Emotional Well-Being*

These are signs that there may be challenges to an infant's emotional well-being.

Slide 14: *Additional Chart Review*

This slide now goes back to the case when Dennis was in early childhood.

Slide 15: *Identifying Mental Health Concerns in Primary Care: Early Childhood (12 months to 4 years)*

This chart shows us the stages of emotional development in early childhood, how to promote and prevent problems in the primary care office, and how to identify challenges early on.

Mental health in early childhood is tightly bound to healthy development in the child, healthy relationships within family, and strong support for both child and family in the community. The child becomes more self-reliant. If a secure base of trust exists in the family, the child will begin to explore, develop autonomy, and begin to identify as a distinct person. This initiates and forms the basis for self-esteem, curiosity about the world, and identity.

Pediatricians should ask parents about their child's play, and how they adapt to new people or situations. Does the child feel free to explore, or does he/she stay by the parent's side? What do the parents do when they see troublesome behaviors? How do they set limits? Questions about temperament could include asking about the child's general activity level, sensitivity or reactivity to changes in the environment, tendency to approach or withdraw in new situations, adaptability to change in routine, and predominance of positive or negative moods. Advise parents to encourage independence in the first couple of years, but include guidance on safety. Discuss discipline, time-ins, time-outs, and redirecting behaviors that they may not want repeated. Anticipatory guidance on temper tantrums, sleep, and toileting can all help a parent understand their child's behavior and need for routine and discipline.

Bright futures provides more specific anticipatory guidance suggestions. For instance, guidance on how to handle stranger anxiety is given. Providers should reinforce to caregivers that this is common and they should not tease their child about this. Parents can promote resilience during stranger anxiety by creating a routine when they leave. They can practice separation during times when a child is not sleepy or hungry and for short periods of time at first. Parents can promote independence by asking their child to make choices. Praising for good behaviors is encouraged.

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Slide 16: *Other Potential Behavioral Concerns That Dennis May Exhibit During This Time*

This slide highlights other potential behavioral problems that could suggest there are challenges in early childhood.

When a child's behavioral patterns, like Dennis, seem off track, the pediatrician should inquire about the behaviors listed on the slide. A history should inquire about developmental capabilities and health status of the child, especially those connected with the behavior in question. Questions about the child's temperament should be asked (distractibility, mood, shy?) as well as the quality of the parent-child relationship, security of attachment; and the relationship between the child and the conditions and demands of the child's environment.

Pediatricians should also ask what the family's understanding of the behavior is, the broader contextual circumstances like stress, and any changes at home or elsewhere.

Slide 17: *Identifying Mental Health Concerns in Primary Care: Middle Childhood (5 to 10 years)*

This chart shows us the stages of emotional development in middle childhood, how to promote and prevent problems in the primary care office, and how to identify challenges early on. Here you can remind the group that this case started with Dennis at age 6. These are the emotional tasks Dennis needs to achieve during middle childhood.

Children during middle childhood continue to develop their independence and a growing interest in the development of friendships. They notice differences from other children and are aware of other's feelings. They continue to develop self-esteem. However, middle childhood is often when mental health problems first present.

Questions during visits in middle childhood should include asking parents if they have concerns about their child's behavior, such as hitting, temper, worries, not playing with others, or irritable mood. As the child gets older, ask him/her about learning too. "What makes you sad, angry, or scared? How do you handle this?" "What are your favorite activities?" "Do you have any concerns or worries?" Anticipatory guidance should focus on school readiness, limitations on TV, family time, routines, and social interactions.

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Slide 18: *What if Dennis First Presented With These Concerns in Middle Childhood?*

This illustrates how many school-aged children present with mental health problems during this time period. While Dennis presented with behavioral problems in infancy and early childhood, had those problems not been discussed or handled, he could have presented now with symptoms of ADHD, anxiety, and mood disorders. Children whose parents abuse substances are at risk for substance abuse at this time.

Slide 19: *Case #1: Back to Dennis*

This slide reminds the group of the initial case.

Slide 20: *Back to Dennis at Age 6: Assessment of His Aggression*

At this point the facilitator can ask the group what more they want to know about Dennis. The goal of this case is really to demonstrate how mental health can be integrated into the medical home. Therefore, the emphasis should be placed on the process, not the true case.

Slide 21-22: *Back to Dennis at Age 6: Assessment of His Aggression*

This slide gives suggested questions on how to obtain a history of aggression.

Conditions or Circumstances:

- What are the conditions or circumstances in which it occurs?
- What is the antecedent? (What happens before the incident occurs?)
- What is the behavior itself? (Kicking, hitting?)
- The consequences of the behavior?
- Why do the parents think the child is behaving this way?

Developmental/Health Status:

- Are there developmental delays that contribute to chronic frustration, including deficits in expressive language and fine-motor abilities?

Temperament and Sensory Processing:

- What is the influence of the child's temperament, especially negative mood?
- Highly impulsive?
- Difficulty in adapting to changes in routine?
- High intensity?
- Usually sensitive to sensory input?
- Has he learned to attack before he is threatened?

Family-Child Interactions:

- Are there stresses to which Dennis may be reacting or that at this point make it harder for his well-intentioned family to manage whatever vulnerabilities he may have?
- Is the child needy or angry because emotional needs are unmet?
- What is the quality of the parent-child attachment?
- Is the child seeking attention?
- Is there overt or covert encouragement of aggression in the family, such as an indicating that parents are proud of the child being "feisty" or showing acceptance of aggression by ignoring it?
- Is there a parental perception that being aggressive is a survival tactic in the neighborhood or community?

Other Environmental Influences:

- Has the child witnessed violence and aggression, especially within his family?
- Has the child witnessed or been exposed to violence or aggression in the community or neighborhood?
- Has he experienced abuse himself?
- Have there been significant disruptions in the life of the family that affects daily routines?
- Unsupervised viewing of violent or mature TV or video games?
- Has the child experienced an adverse life event, such as divorce, a death in the family, or parental substance abuse?

Slide 23: *Early Identification – Diagnostic Assessment*

This slide gives strategies as to how to assess this current problem.

Slide 24: *Discuss Therapy*

This slide should help transition into the common factors approach. The first step is building a therapeutic alliance using common factors. Discuss how it may be better to bring Dennis back for a follow-up appointment to further delve into a diagnostic assessment. Suggest giving the family screening tools complete at home and bring back at the next visit. Later visits may indicate he needs counseling. This should happen in collaboration with the primary pediatrician.

Slide 25: *Traditional Approach*

This diagram is meant to show a traditional approach for handling both chronic physical illnesses (eg, asthma) and mental health issues in primary care. A pediatrician can refer or begin assessment and treatment on their own.

Slide 26: *Common Factors Approach*

This diagram illustrates how a common factors approach may differ from a traditional approach. The upcoming vignette will illustrate how to effectively use a common factors approach for a case of asthma; this should set the stage. This approach emphasizes communication skills, engaging the family, and developing a therapeutic relationship.

The common factors approach (CFA) emphasizes the relationship between the patient, family and caregiver. Partnering with the family to define the problem is the aspect of CFA that is most different from the traditional approach. The CFA emphasizes communication approaches that evidence has documented to be beneficial across a large number of concerns and conditions. It is these “common factors” that not only add to the ability to partner with the family and reach consensus on what problem(s) needs to be addressed, but is also a part of the therapeutic and treatment process. The specific approaches of CFA are described in more detail in Part 2 of this module. It is important to understand and emphasize that CFA is part of both the diagnostic and therapeutic process. In fact, for many common conditions, incorporating CFA may be the primary therapeutic intervention.

At times this alone can help a parent handle a behavioral problem within primary care. For instance, had surveillance and screening occurred during Dennis’ 6 month visit, maternal support and dyadic therapy could have been implemented. To engage the mom and build a therapeutic relationship so this may be successful from the start, a common factors approach can be used. Even at the 6 year visit, building a therapeutic alliance using hope, empathy, and asking for permission to partner with this parent should be the first step in handling this mental health concern. These are strategies that could also be used with a family of a 6 year-old with asthma who has had recurrent admissions and noncompliance with medications.

Role play option: If time allows the preceptor can go back into the room with mom and Dennis and model use of common factors. This role play can also occur at the end of Module 1: Part 2.

Slide 27: *Take-Home Message*

Facilitation Points to Consider

Slide 28: *Title Slide*

Slide 29-30: *Case #2: Jake*

Information Presented to Residents

Jake is a 15-year-old male diagnosed with asthma as a preschooler. He has maintained excellent control of his intermittent asthma symptoms through the use of albuterol as needed. He has managed his exercise-induced symptoms by pretreating before physical activity, including PE class. In the last month, Jake has been experiencing more asthma symptoms. His mother was called at work today to pick him up from school due to wheezing. She has brought Jake to your clinic. He is your next patient.

Additional Information Not Yet Revealed to Residents

In the last month, Jake has been called a sissy and has been pushed around by several classmates because he has to go to the office to take medication before PE class. He has begun skipping his treatments in an effort to avoid the bullying, but it has continued.

Jake's mother is caring for her own mother who is in a nursing home after falling and fracturing her hip. She is not at home as much as usual and is stressed and tired when she is home and remains busy doing household and family chores. Jake's father is not in the picture. She was called today to pick up Jake from school because he was wheezing. She is not aware of the bullying. Jake has kept his struggles to himself.

Slide 31: *Visit With Jake & His Mother*

What goals do you have for this visit?

Encourage residents to share their ideas about appropriate goals. There are no right or wrong goals at this point. The intent with this question is to have residents reflect on and thus be aware of their own agenda when approaching this case.

Example goals:

- Find out if Jake is skipping his medications and why?
- Convince Jake to resume taking his meds regularly.
- Explore the conflict between Jake and his mom; it may be the cause or a clue to Jake's change in adherence to his treatment regimen.
- Build an alliance with Jake and his mother

Slide 32: *Goals & Objectives*

Review the goal and objectives of the session.

Slide 33: *Identifying Mental Health Concerns in Primary Care: Adolescence (11 to 21 years)*

This chart shows us the stages of emotional development in adolescence, how to promote and prevent problems in the primary care office, and how to identify challenges early on.

Development of emotional well-being during this time period centers on the adolescent's ability to effectively cope with multiple stressors and develop psychological resilience.

Ask both the parent and youth:

- How is the youth's relationship with family?
- School performance – *"How is school going?"*
- Mood, coping, anxiety
 - *"Do you think your child worries too much?"*
 - *"How does your child cope with stress?"*
 - *"How do you teach him/her to make decisions and solve problems?"*
 - *"Do you feel stressed out? How do you cope with stress?"*
 - *"It is common for youth to feel ups and downs during adolescence."*

Anticipatory guidance:

- Productive ways to eliminate stress
- Healthy ways to handle failures and celebrate accomplishments
- Encourage discovery and pursuit of new interests
- How the parent can involve the youth in solving problems and making decisions. To help build healthy coping skills, parents can encourage youth to think through solutions, rather than doing the thinking for them.

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Slide 34: *Establishing Alliance*

A core skill for finding a solution to most problems identified in the medical setting is building an alliance with the family. An alliance can also be characterized as a partnership between the pediatrician and the patient and family.

Why start discussion by focusing on alliance building?

- Advice alone isn't enough
 - < 50% of psychosocial concerns disclosed
 - < 50% of mental health referrals kept
 - < 50% of children who start mental health treatment finish

Data from adult primary care studies of depression treatment

- Relationship with provider predicted engagement and outcome
 - van Os TW, van den Brink RH, Tiemens BG, et al. Communicative skills of general practitioners augment the effectiveness of guideline-based depression treatment. *J Aff Disord*. 2005;84:43–51.
[www.jad-journal.com/article/S0165-0327\(04\)00318-0/abstract](http://www.jad-journal.com/article/S0165-0327(04)00318-0/abstract)
 - Fremont P, Gerard A, Sechter D, Vanelle JM, Vidal M. The therapeutic alliance in the initial stages of the management of depression by the general practitioner. *Encephale*. 2008;34:205–210.
www.ncbi.nlm.nih.gov/pubmed/18597730

- Evidence from psychotherapy
 - Alliance predicts outcome over and above any specific treatment (including medications)
- Relationship with pediatrician predicts engagement and outcome of depression treatment in adults.

Slide 35: *Establishing Alliance*

Elements needed to form an alliance when approaching mental health concerns include:

- Agreement on nature of problem
- Agreement on what to do (and when)
- “Affective bond” with the pediatrician
 - Trust in the pediatrician, optimism on the part of the pediatrician, and care that provides relief to the family

Slide 36: *Common Factors Approach: Tools for Alliance Building*

Distribute the tool *Generic or Common Factors Interventions: HELP*. Provide additional information on H-E-L-P items on slide from tool as pertinent to audience.

Slide 37: *Common Factors Review*

Ask residents:

- Questions?
- Does this make sense?

Discuss that using common factors is a way to incorporate skills residents probably already have. The H-E-L-P elements are a set of tools. Any of the tools can be used as appropriate. All tools are not expected to be used in every encounter. The more the tools are incorporated, the more natural the conversation becomes.

Slide 38-40: *Alliance Building & Common Factors – Step 1*

Incorporating **H**ope, **E**mpathy, **L**anguage, and **L**oyalty, how would you begin approaching this situation? What are you going to say next?

Example responses:

- *“I’m sorry to hear that you are having problems with your asthma. I am sure we can find a way to improve the symptoms.”*
- *“That’s too bad that you are having symptoms again after such a long time not having any problems. I’m glad you came in today to get this checked out. With your help, I’m positive we can make things better.”*

Construct an open-ended question for Jake to begin exploring his concerns and thoughts about his mother’s accusation.

Example responses:

- *“Jake, do you have any thoughts on why your asthma symptoms are getting worse?”*
- *“What do you think about your mother’s idea of why your symptoms are getting worse, Jake?”*

Consider having residents construct an open-ended question for Jake's Mom to explore her accusation.

Slide 41-43: Alliance Building & Common Factors – Step 2

Incorporating H-E-L-P, describe an approach for reaching an understanding of **the mother's** perspective.

Example responses:

- Repeat back to the mother what you heard her say she thought was the cause of Jake's exacerbation. Ask her if your understanding of her statement is accurate. (L)
- Ask the mother if it is okay for you to ask some more in-depth questions to better understand the problem and thereby be better able to develop a plan for improvement.
 - *Example: "I am concerned about this unusual exacerbation of Jake's symptoms. I'd like to ask you a few more questions to get a better understanding of what has changed if that's okay with you." (P)*
- Ask the mother if she thinks there might be any alternate or additional causes of the symptom exacerbation.
- If the mother expresses emotions beyond concern for Jake (eg, anger, frustration), offer your observations of those emotions to the mother for clarification.
 - *Example: "You sound very frustrated when talking about this. Is that how you're feeling? What about this is frustrating for you?"*

Share with the residents that as a result of this approach and your active, empathetic listening, you discover that she is stressed out due to the extra burden of supporting her mother in a nearby nursing home during her recuperation from a fall and fractured hip. She reports that between her full time job and caring for her mother, she has very little time at home right now, most of it spent cooking, cleaning and paying bills.

Incorporating H-E-L-P, describe an approach for reaching an understanding of **Jake's** perspective.

Example responses:

- Ask Jake what he thinks is causing his symptom exacerbation. Ask further if he can think of any alternate or additional contributing problems. Repeat back what Jake shares asking if you understood him correctly. (L)
- Let Jake know that you want to help him get better (L) and assure him that you believe you can with his help. (H)
- Ask Jake for permission to ask more in-depth questions. (P)
 - *Example: "Jake, is it okay if I ask you more about your symptoms and your medication to help me figure out how best to help you?"*

Share with the residents that as a result of a calm and empathetic manner used in asking questions about the specifics of his day, the timing and context of his symptoms and the timing of his medication along with general questions about how things were going at school and with friends, Jake revealed that he was being called a sissy and being pushed around for having to go to the school office to take the medication prior to PE. He acknowledged that he has been skipping going to the office to avoid bullying.

Slide 44-45: Alliance Building & Common Factors – Step 3

Construct a question to ask the mother for permission to give advice.
Construct a question to ask Jake for permission to give advice

Example responses:

- *“Thank you both for sharing with me your thoughts about what’s going on. I believe we can develop a plan to help deal with this. Is it okay to start talking about what to do next, Mom? Jake?”*
- *“Do you have any questions to ask or additional information to talk about before we discuss what to do next? If not, is it okay with you to begin discussing next steps to deal with the issues we’ve discussed?”* (asking Jake and his Mom individually).

Slide 46: Summary of Common Factors Approach

Working through these concerns with Jake and his mother have illustrated how using the Common Factors Approach (CFA) is similar to the traditional medical model approach but adds to the process, and can result in an improved outcome for the patient. Using only the traditional model of medical problem solving would not as likely have identified the additional psychosocial issues that were interfering with Jake’s compliance. In fact, it may have well added to the power struggle that was developing between Jake and his mother.

By using CFA tools, the diagnosis of the underlying problem could be identified, AND partnering with the family to develop a plan to address the psychosocial concerns became the key aspect of treatment. Using CFA tools will likely prevent the need for additional referrals that are not likely to be kept. Remember the <50% outcomes in Slide 34.

Slide 47: Closing

Slide 45 addresses approaches to advice giving, however it does not address specific advice for this situation. Depending on your time availability, you may choose to discuss where to find evidence-based approaches to being bullied (eg, AAP Mental Health Toolkit, literature review, textbook review, etc).

Review the 3 steps for alliance building and the common factors tools, pointing out that this approach can be beneficial for medical concerns as well as mental health concerns. As illustrated in the case vignette, mental health concerns may present as medical problems.

If additional modules in this curriculum will be used, let the residents know what the next topic is and when it will be discussed.

Role play option: If this module is presented close to part 1, you can use role play #3 at this point where the preceptor models using common factors in the room with Dennis’ mother and the resident. See role play materials.