



# Common Factors Approach: HEL<sup>2</sup>P<sup>3</sup> to Build a Better Alliance

“Common factors” communication skills, so named because they are components of effective interventions common to diverse therapies across multiple diagnoses, are foundational among the proposed pediatric mental health competencies. These communication techniques include clinician interpersonal skills that help to build a therapeutic alliance—the felt bond between the clinician and patient and/or family, a powerful factor in facilitating emotional and psychological healing—which, in turn, increases the patient and/or family’s optimism, feelings of well-being, and willingness to work toward improved health. Other common-factors techniques target feelings of anger, ambivalence, and hopelessness, family conflicts, and barriers to behavior change and help seeking. Still other techniques keep the discussion focused, practical, and organized. These techniques

come from family therapy, cognitive therapy, motivational interviewing, family engagement, family-focused pediatrics, and solution-focused therapy.<sup>1</sup> They have been proven useful and effective in addressing mental health symptoms in pediatrics across the age spectrum and can be readily acquired by experienced clinicians.<sup>2</sup> Importantly, when time is short, the clinician can also use them to bring a visit to a supportive close while committing his or her loyalty and further assistance to the patient and family—that is, reinforcing the therapeutic alliance, even as he or she accommodates to the rapid pace of the practice.

The mnemonic HEL<sup>2</sup>P<sup>3</sup> summarizes components of the common factors approach.

<b>H = hope</b>	<b>Hope</b> facilitates coping. Increase the family’s hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you recognize in the child and family. Encourage concrete steps toward whatever is achievable.
<b>E = empathy</b>	Communicate <b>empathy</b> by listening attentively, acknowledging struggles and distress, and sharing happiness experienced by the child and family.
<b>L<sup>2</sup> = language, loyalty</b>	Use the child’s or family’s own <b>language</b> (not a clinical label) to reflect your understanding of the problem as they perceive it and to give the child and family an opportunity to correct any misperceptions.  Communicate <b>loyalty</b> to the family by expressing your support and your commitment to help now and in the future.
<b>P<sup>3</sup> = permission, partnership, plan</b>	Ask the family’s <b>permission</b> for you to ask more in-depth and potentially sensitive questions or to suggest further evaluation or management.  <b>Partner</b> with the child and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and find agreement on achievable steps (or, simply, an achievable first step) aligned with the family’s motivation. The more difficult the problem, the more important is the promise of partnership.  On the basis of the child’s and family’s preferences and sense of urgency, establish a <b>plan</b> (or incremental first step) through which the child and family will take some actions, work toward greater readiness to take action, or monitor the problem and follow up with you. (The plan may include keeping a diary of symptoms and triggers, gathering information from other sources such as the child’s school, changing lifestyle, applying parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, initiating specific treatment, seeking referral for further assessment or treatment, or returning for further family discussion.)



## References

1. Wissow L, Anthony B, Brown J, et al. A common factors approach to improving the mental health capacity of pediatric primary care. *Adm Policy Ment Health*. 2008;35(4):305–318
2. Wissow LS, Gadomski A, Roter D, et al. Improving child and parent mental health in primary care: a cluster-randomized trial of communication skills training. *Pediatrics*. 2008;121(2):266–275

Excerpted from Foy JM, Green CM, Earls, MF; American Academy Committee on Psychosocial Aspects of Child and Family Health, Mental Health Leadership Work Group. Mental Health Competencies for Pediatric Practice. *Pediatrics*. 2019;144(5): e20192757; <https://pediatrics.aappublications.org/content/144/5/e20192757>

## Additional resource: Implementing Mental Health Priorities in Practice

Developed with support from the Friends of Children Fund, this resource consists of 6 videos demonstrating examples of patient/family encounters that encompass the most difficult conversation areas for the following mental health topics: social emotional problems in children birth to 5, depression, inattention and impulsivity, disruptive behavior and aggression, substance use, and self-harm and suicide. Available at [https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/implementing\\_mental\\_health\\_priorities\\_in\\_practice.aspx](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/implementing_mental_health_priorities_in_practice.aspx)

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original resource included as part of *Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians*, 2nd Edition.

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