

## 9. EXAMPLES OF CONSULTATIONS WITH YOUTH AND THEIR FAMILIES

“The proper time to influence the character of a child is about a hundred years before he is born.”

William Ralph Inge

Pediatricians spend 25% to 60% of their time in well child care visits, and these typically include screening and assessment of developmental issues, anticipatory guidance, and identification and treatment of behavior problems. Therefore, pediatricians and their family medicine colleagues are in an ideal position to detect and address the psychosocial problems impacting the health of children and youth. Of course, there are numerous barriers, including time, difficulties communicating psychosocial concerns clearly, an overly bio-medical orientation within PC, the lack of effective screening processes and, historically, the absence of integrated behavioral health services in the clinic. BHC services have the potential for reducing these impediments, and this chapter provides illustrations and information for improving children’s health by addressing psychosocial problems effectively.

As many as a quarter of primary care pediatric patients present with significant psychosocial dysfunction (Costello et al., 1988; Horwitz, Leaf, Leventhal, Forsyth, & Speechley, 1992; National Institute of Mental Health, 1990; U.S. Public Health Service, 2000). Most are living their childhood years in contexts that include a plethora of adverse experiences, and, without detection and intervention, these experiences function in an additive fashion to harm the child’s health as an adult. The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998; Felitti, 2002), interviewed over 17,000 adults to determine the prevalence of events in

five categories of household dysfunction and three categories of abuse during childhood. Participants received ACE scores based on the number of events experienced, with scores ranging from 0 to 8 events. Many adult health problems proved to have a strong, linear relationship to ACE scores, including heart disease, fractures, diabetes, obesity, unintended pregnancy, sexually transmitted diseases, and alcoholism. As ACE scores increased, job performance worsened progressively as did the probability of problematic health and health risk behaviors. For example, a person with an ACE Score of 4 was 260% more likely to have chronic obstructive pulmonary disease (COPD) than a person with an ACE Score of 0. A person with an ACE score of 6 was 600 times more likely to be an intravenous drug user than a person with a score of 0. Additionally, results indicated that adverse events occur more frequently in childhood than most people imagine. For example, almost one in four of the ACE subjects reported some form of childhood abuse.

This chapter will look at opportunities the BHC has for responding to the healthcare needs of children and adolescents inherent in the day-to-day work of a BHC. Come in, sit down, jump up, and walk down the halls with a BHC on a Monday morning and learn about six patients and the opportunities for program development and PCP teaching inherent in consulting with these particular patients (and the many others with similar problems). For some case examples, we provide examples of documentation (e.g., a SOAP note) and suggest use of patient education materials. Appendix B offers a reading list for BHCs to use to increase their skill base for developing interventions for children, adolescents and their families, along with a book list for children and parents. Appendix D offers a compact disc that includes patient handouts (e.g., Enuresis Plan, Designing Reward Plans, Great Reward Ideas, and Using Time-Out with Your Child). Table 9.1 provides an overview of the chapter, along with the BHC

schedule and the reasons for referral. We encourage you to slow your reading momentarily after each patient and ask, “What are the prevention opportunities here?” We hope your answers help to improve the character of children who come into the world after this book is written.

So let your imagination take over—you are in a primary care clinic looking over the shoulder of a BHC. Since most clinic days bring a variety of child and adult patients, let’s pretend it’s a school holiday and your morning schedule involves only children and adolescents.

Table 9.1

Chapter 9 Overview: A Morning in the Life of a BHC (Providing Care to Children)

CHAPTER SECTION	BHC # 1442	REFERRAL REASON
Young Children with Behavior Problems	8:15 Lucille	Annoying Behaviors, Irritability
Overweight and Obese children	8:45 Juan	Weight Gain, Sadness
Children with Aches and Pains	9:15 Rita	Abdominal Pain
Children with Social Problems	9:45 Paul	School problems
Children Recovering from Trauma	10:15 Mary	Unplanned Pregnancy
Children with ADHD	11:00 Samuel	School Problems

### YOUNG CHILDREN WITH BEHAVIOR PROBLEMS

Behavior problems are common with young children, and many are detectable by age two or three. It is quite possible that BHCs could help PCPs identify children at risk by

screening their parents at the 1-year physical. We, in fact, know of at least one PCBH program where EVERY well-child visit starts with a brief BHC screening interaction. With integrated behavioral health services, there's no need to wait until children, like Lucille, come to the clinic with annoying behaviors.

My daughter (Lucille) is annoying me.

Dr. Chan referred this 3-year-old patient for a consultation concerning development of parenting skills, after the patient's mother complained that her daughter was annoying to her a great deal of the time. At the consultation, the mother, who was pregnant with a second child, reported that she worried about Lucille's relationship with her father, as she was developing a pattern of saying no to many of his requests and the father felt hurt by this. The BHC inquired about the mother's interest in learning more about parenting, and she agreed. After providing basic information about positive reinforcement strategies, the BHC explored the mother's concern about the father's responses to Lucille's no-no-no behavior (an example of a behavior that annoyed the mother) and explained that this demonstrates how unwanted behaviors increase if the response is increased parental attention. The BHC helped the mother to develop a program involving the father using a star chart to positively reinforce Lucille for saying yes. Additionally, they planned for the father to ignore Lucille's no-no-no behavior or turn it into a game of no, no, no, yes, yes, no—engaging her in a guessing game about when the father would switch from no to yes. The BHC explained that such games help to take the provocative meaning out of the word “no”, and place it in a new context (in this case, the context of play which supports a positive father –daughter relationship).

At the end of the visit, Lucille's mother voiced a desire to reduce the frequency of her daughter's requests for nursing at night. The BHC helped mother plan a program for this,

involving the mother asking Lucille to try to refrain from making the requests, so that the mother would be rested and ready to have a special morning play time with her. When Lucille made the request, the mother would give her a choice between having a snack and getting a “smiley face” sticker or nursing. Additionally, she would remind Lucille that she could put the sticker beside Mom’s bed if she wanted to exchange it for 15 minutes of reading and cuddling with Mom the next morning in her bed.

Since Lucille’s mother and father wanted to read a book on parenting and to attend a class, the BHC suggested a book and provided information about an up-coming class in the community. The BHC asked that patient’s mother to follow-up with Dr. Chan within a month and to return for a follow-up with the BHC if she did not obtain desired results within a few weeks of starting the planned programs. In follow-up with Dr. Chan, the mother reported that she had implemented the plans and that both concerns were resolved. She did not attend the parenting class due to time conflicts, but was watching a program on parenting on television.

Intervention Possibilities for Young Children with Behavior Problems. The case example of Lucille demonstrates the importance of a good functional analysis. The BHC’s plan focused on improving Lucille’s relationships with her mother and father, as it was stress in these relationships that made her vulnerable to the reported behavior problems. Parents often lack the perspective to perceive the evolution of these circumstances, and the PCP often lacks the time (and skill) to complete a functional analysis.

Table 9.2 suggests possible approaches for BHCs to use to increase basic parenting strategies and apply specific behavior change techniques to common behavior problems, which often arise at family transitions points. The BHC can teach behavior change and parenting strategies in individual BHC consultations by integrating them with programs developed

through a functional analysis of a target behavior, as was done with Lucille and her mother. Additionally, the BHC may recommend specific reading and/or provide opportunities to practice skills. Many parents will read pamphlets, articles or books and/or watch videos about parenting, with or without BHC consultation visits. There are many good books related to parenting, and we provide a list of possibilities in Appendix B.

Table 9.2

BHC Intervention Possibilities for Young Children with Behavior Problems

1. Integrate instruction in parenting with behavioral programs resulting from a functional analysis.
2. Provide pamphlets or articles on common behavior problems and parenting strategies.
3. Recommend specific books on parenting and/or The Home Chip System.
4. Notify PCPs and patients of parenting class resources in the community.
5. Develop a PCBH parenting protocol that the BHC can deliver in a time-effective manner over time, perhaps on a same-day basis in tandem with the child's medical visits.

The BHC might also provide information about The Home Chip System, which is an excellent program for parents of three- to seven-year-olds that have behavior problems (Christophersen & Mortweet, 2003). The procedures in The Home Chip System have been used in families with parents whose education ranged from less than high school to postgraduate studies and with income levels ranging from poverty to upper-income professional. This approach has also been used with families from a variety of ethnic and racial backgrounds.

Another possibility involves the BHC networking with community-based parenting class teachers, posting notices about upcoming series, and providing reminders to parents and PCPs about start dates. Unfortunately, many, if not most, parents will not participate for a variety of reasons—such as work schedules and lack of resources for childcare. For parents who prefer to learn parenting skills in consultation visits with a BHC, the BHC may find that use of a protocol improves his or her consistency and time-effectiveness. Table 9.3 offers an example of a parenting protocol that a BHC can deliver in a series of one-to-one consultation visits, in classes or in a one day workshop. This protocol entails a minimum of three consultations and an optional fourth visit. When parents are in conflict about numerous issues related to parenting, we suggest that the second contact focus on teaching skills related to effective conflict resolution and ways to present a united front. Then, the second visit in the protocol becomes the third and the third the fourth.

Table 9.3

Teaching Parenting Skills: A Protocol for the BHC

BHC CONSULT VISIT	SKILL FOCUS	HANDOUT TOPICS
Initial	Improving the Parent-Child Relationship	Positive Parenting
Second	Building Skills for Setting Limits and Using Incentive Programs	Setting Limits and Using Incentives and Consequences
Third	Building Skills for Using Ignoring and Time Out and	The Power of your Attention and a United

	Working as a Team	Front
Fourth (optional)	How to Model Effective Conflict Resolution and Present a United Front	No handout

In the initial visit, the BHC helps the parent(s) develop a plan to improve their relationship with the child. Content includes information about modeling and planning and engaging in playful activities that improve communication and respect. The BHC may help the parent(s) develop a value statement concerning the qualities of parenting and the lifestyle behaviors that he or she wants to model for the child (children). Parents may set small goals (e.g., spending 15 minutes each day with each child engaged in active listening or exercising for 15 minutes daily) to improve the consistency between daily activities and valued styles of parenting (e.g., being a good listener, modeling healthy lifestyle behaviors).

In the three-contact model, the second and third contacts provide the parent(s) with a variety of skills. The second consult includes instruction about providing clear commands, setting limits and the details of using incentives and consequences. The BHC can explain and model strategies such as the when-then command in five or 10 minutes. This involves the parent deciding exactly what they want the child to do and then determining what incentives are available to reinforce compliance with the request. Once the parent has these two elements in mind, he or she can explain to the child, “When you do “X” (i.e., put your backpack in your room; finish the dishes), then you can do “Y” (i.e., continue with your play; go to the store with me).” The third contact involves more training concerning the use of positive attention to influence the child’s behavior, including procedures for ignoring unwanted behaviors and

establishing time out as a contingency. This consult also includes a brief discussion of the importance of both parents presenting a united front to the child.

After the series, the BHC asks the patient and his or her parents to follow-up with the PCP. At follow-up, the PCP needs to assess parental confidence in implementing their newly learned skills and devise a support plan that is adequate for solidifying skill gains over the next six months. BHCs may develop parent education handouts for specific visits in a parenting protocol, and these may be shared with the PCP so that they can provide informed support to parents over time. The content of this recommended protocol is consistent with empirically supported programs detailed elsewhere (see Webster-Stratton, & Herbert, 1994). It is a good option for parents who are unable to attend community classes, as it can be delivered to them in a series of same-day visits over time.

PCP Teaching Points Concerning Young Children with Behavior Problems. Many PCPs were not exposed to basic principles of behavior modification in medical school. The context of teaching parenting strategies is a great one for introducing PCPs to the ubiquitous and useful concepts of positive reinforcement, extinction, negative reinforcement, and schedules of reinforcement. As suggested in Table 9.4, the BHC can use PCBH newsletters as well as articles to provide information about managing behavior problems and positive parenting strategies, such as star charts, time out procedures, and differential reinforcement of other behavior (DRO) schedules. Individual consultations provide an opportunity for the BHC to demonstrate application of techniques presented in written educational materials and/or BHC workshops for providers. It is important to keep in mind that providers vary in their level of interest in behavior change technology. Some will order and read a book on parenting and schedule a time with the BHC to discuss the book. At the low interest end of the continuum, a

few will simply continue charting when the BHC talks about negative reinforcement. Most will be somewhere in between. Offering on-going parenting classes or workshops is another way to further disseminate behavioral strategies focused on parenting and child behavior problems, as providers may be able to attend classes that are offered at the end of the patient care day or on weekends. Additionally, a BHC may provide copies of brief articles on common parent-child issues and parenting skills (e.g., lying, emotion regulation, praise, etc.) in a wall hanger near his or her office and E-mail PCPs about their availability.

Table 9.4

PCP Teaching Points Concerning Young Children with Behavior Problems

1. Teach the method of functional analysis when giving feedback on the development of a behavior modification program.
2. Use PCBH newsletters to reinforce specific behavior change and parenting strategies.
3. Invite PCPs to attend classes and workshops on parenting that the BHC teaches.
4. Provide copies of articles about management of common behavior problems on the BHC's door (or other highly accessible areas).
5. Teach providers how to talk with parents and young children about their values and how to help them set small goals for change that are consistent with their values (e.g., pursuing the value of being a kind parent by setting a goal of giving descriptive praise statements for a specific behavior twice hourly).
6. Teach providers to teach parents to play with words with children in order to avoid needless power struggles (e.g., the no-no-no game).

PCPs will also respond positively to BHC efforts to introduce concepts related to modeling, identifying values, setting small goals that increase consistency between daily activities and values, and turning power struggles into word games. The best way to convey these ideas is through case discussions. While some of these strategies derive from Acceptance and Commitment Therapy, the BHC need not pass along any psychobabble in order to relay their essence. Strategies such as value directed behavior change and defusion are new tools that may be of use when older tools are inadequate or require more time. Often, these newer approaches enhance the impact of tried and true behavioral parenting strategies. The BHC could use the consultation with Lucille to teach the PCP about the process of fusion and the strategy of defusion. Lucille had “no” in a response class that included refusing to cooperate, being stubborn, and perhaps being independent. “No” fused with negative emotional states (her own and her fathers), including anger and sadness. The father perhaps had his own fusion problem going as well, with his daughter’s refusal behavior pulling forth a response class, or group of associations, that included being disliked, unloved, and perhaps inadequate. The defusion technique involved repeating the word no repeatedly, with variations in volume and speed and with unpredictable interjections of yes, and the result was the loss of problematic properties of “no.” The word “no” would continue to appear in their interactions, but its function was changed, and the father and daughter could now play and enjoy each other.

#### OVERWEIGHT AND OBESE CHILDREN

In the United States, 10% of two-to five-year olds and 15% of six- to 19-year-olds are overweight (Ogden, Flegal, Carroll, & Johnson, 2002). Children that are overweight or obese face many social challenges and are at risk for developing additional health problems as they

grow into adulthood. Many of these youngsters, like Juan, seek comfort in food and eating, as it provides a respite from adverse events in their dysfunctional homes.

The doctor says he (Juan) weighs too much.

Dr. Funk referred this 14-year-old patient for a consultation concerning weight gain, fatigue, and sad mood. At the consultation, Juan reported that he had followed Dr. Funk's recommended changes in diet and exercise regimes. He was eating more fruits and vegetables; walking with his step-father, and playing soccer with his brothers. He said that he hoped to lose 40 pounds. The BHC provided educational information and written materials to help Juan distinguish between a diet and a healthy lifestyle and, based on the results on a functional analysis, focused planning around addressing emotional eating, as it could present a barrier to patient's long-term establishment of a healthy lifestyle.

Juan indicated significant life stresses, including conflicts between his parents that had lead to their recent separation. His description of his father's behavior suggested problems with emotional instability. Juan explained that his father had attempted suicide when he and his sister requested permission to live with their mother. While his grades were mostly C's, Juan wanted to make A and B grades and to grow up to be an artist. He agreed to continue his new healthy lifestyle behaviors, look for a recommended book on art and drawing, and return for follow-up with the BHC in two weeks. The BHC also asked Juan to notice when he felt upset or worried and what he did at those times. They planned to talk about more about emotional triggers for eating and strategies for self-care when family members are upset and acting unpredictably.

Juan returned for follow-up three weeks later and reported some improvement in his family situation. He was continuing to eat smaller portions and to be physically active; he was

avoiding fast foods and soda, and he was drinking one glass of water for every glass of juice. Juan was monitoring his weight and was pleased to report that he was not gaining weight. Juan told the BHC that he felt afraid when his father talked loud or said bad things about his mother and that he tended to use favorite foods to both calm and distract himself when these situations arose. He also reported that he would turn the TV on after overeating to further avoid the unpleasant home situation. The BHC taught Juan a strategy for breathing and focusing on the here and now, so that he could make room for fear and painful memories of his parents' arguments, while choosing to engage in healthy lifestyle behaviors. They also made a safety plan for Juan in the event his father's behavior became unusually erratic during a visit.

Juan returned for a third consult during the summer and indicated that his relationship with his father was improving. He was swimming and planned to join a swim team in the fall. He had continued to practice the breathing and mindfulness exercises and had lost six pounds. The BHC supported his gains, and helped Juan schedule a follow-up visit with his PCP in three months.

BHC Intervention Possibilities for Obese and Overweight Children. Children with weight control problems, as well their parents (who are often also overweight or obese) may lack both the information and skills necessary to change their behavior. In the case of Juan, the BHC provided handouts that reinforced some of the concepts that Juan had heard from other providers, including his PCP and the dietician. With these children, a team approach is critical as it increases the availability of social support as well as giving the child a consistent "message". The BHC can develop brief handouts that suggest guidelines for healthy eating, exercise and sleep and share them with patients, PCPs, and dieticians. In this case, the functional analysis identified a pattern of dysfunctional eating that functioned in the service of

regulating painful emotions, and the homework assignment included self-monitoring to gather further information about this link. The case also illustrates the value of broadening the focus on the child to include his or her development into adulthood where work is a part of their lives. Some overweight children may tend to avoid day dreams about their future, as this might have become associated with self-critical and rejecting thoughts about physical appearance and the likelihood of future success.

As can be seen in Table 9.5, we recommend that the BHC provide other educational services to these children. For example, the BHC may explain the impact of stress on health and one's ability to make healthy choices. Without skills for reducing various psychosocial stresses, one may be unable to generate energy and concentration for food preparation and instead rely on fast food and snack foods that are high in calories and low in nutrients. Turning on the television, of course, helps distance oneself from directly experiencing distressing emotions, as does emotionally triggered overeating and/or making poor food choices. Children and parents are often surprised to learn that the probability of being overweight as a child increases in proportion to the amount of time spent watching television.

Table 9.5

BHC Intervention Possibilities for Obese and Overweight Children

1. Provide guidelines for healthy lifestyle behaviors related to eating, exercise and sleep.
2. Discuss the impact of stress on one's ability to make healthy choices and implement them (i.e., increasing levels of stress in the absence of skills for reducing it may provoke ineffective avoidant patterns of behavior involving food and sedentary activities).

3. Ask about the patient's rate of viewing television, playing video games, and engaging in other sedentary activities.
4. Ask about the patient's ideals concerning physical health and caring for his or her body and assist with planning specific goals that move the patient toward his or her own standard.
5. Use motivational interviewing to select the initial area of lifestyle change (e.g., diet versus exercise versus sleep) to stack the deck for enhancing self-efficacy.
6. Complete a functional analysis concerning any recurring pattern of eating larger portion sizes or eating in the absence of hunger sensations.
7. Address skill deficits that pre-dispose the patient to dysfunctional eating behaviors (e.g., lack of mindfulness skills, relaxation strategies, and/or safety plans that address high risk family situations).
8. Address any problematic parental response to patient's eating behavior (e.g., attempting to over-control patient's access to food or denying the negative health consequences of being overweight or obese).
9. Offer workshops and classes for families that teach skills for adopting healthy lifestyle behaviors.

The BHC may weave educational activities with motivational interviewing strategies in an effort to engage the child (and parent) in developing a plan that focuses on an area of life style change where motivation is greatest. This approach also works well with pre-diabetic or diabetic children. For example, the BHC might read through a one-page handout offering three or four guidelines for healthy eating, exercise and sleep and ask the child to choose one

behavioral goal that interests him or her. Some children may like the idea of planning to eat breakfast daily while others prefer to make a plan of riding their bike everyday.

For some children, the functional analysis may center on behavior patterns linked to eating larger portion sizes or eating in the absence of hunger sensations. This may help identify deficits in coping skills (which are often present in this behavior pattern) and help direct coping skills training. In addition to television viewing, overweight or obese children may have high rates of other sedentary behaviors (playing video games, reading), so the BHC may inquire about these as well. The function of the sedentary activity varies from child to child, but often includes avoiding emotionally or behaviorally challenging circumstances in their homes (e.g., loneliness, problematic parent-child relationships, domestic violence, etc.). Once overweight, children find sedentary activities even more attractive, as they provide entertainment that is free of the discomforts of peer teasing about weight as well as the pain and awkwardness of exercising when one is overweight. Mindfulness skills are empowering to children who are emotional and/or behaviorally avoidant. A simultaneous focus on values related to taking care of one's body can enhance motivation and set the stage for development of a long term, resilient action plan that the child can implement with parent and PCP support.

BHC interventions need to also address the needs of parents, as they often struggle in a variety of ways. They may attempt to control patient access to food, which usually does not work well. Many children will rebel against perceived attempts to restrict access to food and may even eat more. Parents who are overweight may minimize the importance of changing eating patterns, and they may suggest to the BHC, "We like him the way he is—just a little heavy." Educating parents about calculation of the Body Mass Index and health consequences of obesity are useful, but even more empowering interventions are those that enhance the

parents' level of motivation for modeling a healthy lifestyle and in engaging in healthy lifestyle behaviors together with the child.

Given the growing prevalence of overweight and obese children, BHCs need to support expansion of both prevention and intervention efforts on their behalf. Classes and workshops that empower development of a healthy lifestyle may be useful. For example, one of us (PR) works in a clinic that offers a six-session group program for children and their families that combines a weight management and diabetes prevention curriculum (Bienestar Health Program, see Trevino et al., 1998) with behavioral parent training.

Discussion: Teaching Points for Primary Care Providers. BHCs need to encourage medical providers to routinely refer overweight as well as obese children and their families for a consultation. The addition of behavior change expertise enriches a lifestyle change plan and enhances the opportunities for generating motivation for change in the child and, in some cases, may prevent an escalation in conflict between child and parent(s). As suggested in Table 9.6, handouts may help PCPs remember to refer, and clinical pathways that suggest referral for dietician and BHC services may also support PCP consistency in using BHC services. Overtime, prevention workshops will probably become common in primary care centers, and this will support PCP efforts to learn interventions commonly used by BHCs in consultations with these children and their families.

Table 9.6

PCP Teaching Points Concerning Young Children with Behavior Problems

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| <ol style="list-style-type: none"> <li>1. Provide handouts that offer guidelines for healthy lifestyle behaviors and suggest that PCPs provide such to the patient when referring for a consultation with the BHC and</li> </ol> |
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dietician.

2. Suggest use of a clinical pathway that directs the PCP to refer overweight and obese children and their families for consultations with the dietitian and the BHC.
3. Invite PCPs to attend (or co-lead) workshops and classes provided by the BHC on the topic of healthy lifestyle behaviors.

### CHILDREN WITH ACHES AND PAINS

The BHC will see many different types of children with pain complaints. For example, children with cancer, AIDS, sickle cell disease, and rheumatoid arthritis often report on-going pain. About 3% of children younger than age 18 experience headaches (Newacheck & Taylor, 1992), while 9% to 17% of school-age or younger children experience recurrent abdominal pain (Zuckerman, Stevenson, & Bailey, 1987). Other children experience pain in conjunction with medical procedures. All of these children may benefit from BHC services. When seeing pediatric pain patients, the BHC needs to pay close attention to parental responses to pain, both the child's pain and the parent's pain. As the consultation with Rita demonstrates, this is often a significant factor in the development (and resolution) of problematic pain behaviors.

Rita: My tummy hurts.

Dr. Moore referred this 4-year-old girl for a consultation concerning abdominal pain. Rita's pain complaint had started eight months prior at about the same time that she began to occasionally fall on the floor and yell. These episodes tended to occur when her mother told her to stop or start something not to her liking. Rita's mother's response was to focus on the pain complaints and to shower her with comforting hugs and kisses. The stomach pain and tantrum events often escalated when Rita visited with her cousins and the mother insisted that she share

her toys with them. Being an only child, Rita had limited opportunities for learning how to share, and her mother did not know that sharing behavior often required parental coaching. The mother was pregnant, and Rita was not eager to have a brother or sister that might try to take her toys away. Rita also thought that the baby might hurt her mother's tummy.

In the first of a series of three consultations (a total of one hour of service), the BHC helped Rita's mother develop a star chart program to reinforce compliance and a time out procedure for non-compliant and tantrum behaviors. The BHC also provided a few suggestions on how to set up a series of learning sessions concerning sharing behavior, which included having Rita select toys to take with her to share with her cousins and leaving toys she did not want to share at home. The BHC taught Rita and her mother to use belly breathing and a circle tummy massage to relax when their growing tummies growled or hurt. Mother agreed to use her hugs and kisses to reinforce compliant and sharing behavior and to prompt her child to engage in the breathing and self-massage activity when she made a pain complaint. The BHC also suggested a plan for strengthening their relationship in preparation for the addition of a new family member. This involved their making a list of all of the privileges and responsibilities accorded to a big sister and a second list of special mother-daughter and father-daughter activities that Rita would do alone with her parents starting now and continuing after the birth.

While asked to return within two weeks, patient and her mother returned two and one-half months later. At that time, the mother was less concerned about Rita's abdominal pain and more concerned about her behavior. The mother had used the star chart with some success, but stopped after the birth of the baby, who was now three weeks old. She had tried time out, but had not been able to follow through when Rita was not quiet in time out. She insisted that she

had no time to spend one-to-one with Rita, who was of course very jealous of the attention the mother gave to the new baby. Rita was talking like a baby, and this was annoying for the mother. Rita continued to be slow to follow her mother's requests, but was following her father's requests most of the time.

The BHC reviewed the basics of creating a positive parent-child relationship, modeling, positive reinforcement, extinction, and time out. The mother agreed to target Rita's independent behavior for positive reinforcement. Additionally, she agreed to ask Rita's father to spend 15 minutes alone with her on a daily basis and, then to watch the new baby so that the mother could also consistently spend at least 15 minutes alone each day with Rita. The BHC carefully described the qualities of play and its importance in building a strong parent-child relationship.

While Rita's mother agreed to return for follow-up in two to three weeks, she came with her child for a third consult six weeks later. Mother reported spending more time alone with patient and praising her frequently for independent and compliant behaviors. Patient was not having abdominal pain, was following mother's commands more often, and was generally less irritable and more active. The mother agreed to go to a parenting class that offered day care and to follow-up with the BHC after the class if she felt it necessary.

BHC Intervention Possibilities for Children with Aches and Pains. This case example highlights several important aspects of treating childhood pain complaints and behavior problems. First, it is important that the BHC address the pain problem and teach a coping skill to the patient and the parent. An important aspect of this intervention is obtaining a commitment from the parent to model the coping skill and to prompt its use when the child complains of pain. Another important principle is that these families often are experiencing a

great deal of stress. This may influence their ability to absorb information in a consult and to follow through on more complicated interventions. Rita's BHC worried about Rita's escalating behavior problems, given the mother's lack of skills and somewhat detached attitude toward her. In trying to give the mother the whole enchilada of parent training rather than a few manageable bites, the BHC may have overwhelmed the mother, as she clearly did not have a grip on how to implement a time-out reinforcement at the follow-up visit. BHCs face difficult choices in time-constrained settings, and we recommend erring in the direction of simplifying and limiting the intervention. Another important point concerns her mother's failure to return at the planned time. This happens fairly often with BHC patients, and the job of the BHC is to avoid a power struggle with the patient and simply evaluate how the plan has worked since the last visit, troubleshoot obstacles and modify the ensuing plan accordingly. \

In terms of therapeutic interventions for pain, cognitive-behavioral therapy (CBT) is the best researched non-pharmacological intervention, and emerging research suggests that ACT interventions may augment clinical outcomes (Robinson, Wicksell & Olssen, 2005). CBT strategies may include breathing exercises, distraction, imagery, relaxation training, modeling, behavioral rehearsal, and reinforcement. These strategies, along with other interventions listed in Table 9.7 are useful for children with many different pain problems. With parents who experience excessive levels of distress in response to a child's pain, the BHC will need to pay particular attention to assisting the parent. The response of well-intentioned parents may lead a sensitive child to fear that something—of a physical nature—is dangerously wrong with them. Children may be particularly vulnerable to this when someone in their immediate or extended family has been acutely ill or has had symptoms of illness over a prolonged period of time that could not be medically explained. In a worse case scenario, a parent experiences a child's pain

as if it was his or her own pain and both see the pain as dangerous. In this scenario, both the child and the parents won't settle for anything less than complete elimination of the pain. The BHC can help them shift from the unachievable goal of eliminating pain to an acceptance of the fact that some level of pain will be present. The goal is to not allow pain to function as a barrier to activities and pursuits that are valued by the child. This may involve helping the child and parent explore their elimination goal, the methods they've employed in pursuit of it, and the results obtained thus far.

Table 9.7

BHC Intervention Possibilities for Children with Aches and Pains

1. Complete a functional analysis on the pain or ache, being attentive to parental response and parental modeling.
2. Teach the child a method for coping with the pain.
3. Limit your intervention in each visit to one or two skills, even when the child and family seem to need a great deal of help.
4. When the child and parent see the pain as dangerous and insist that it be eliminated, help them shift to a goal of experiencing the pain in a less distressing context.
5. When the pain functions to help the child to obtain parental affection or avoid undesirable activities (e.g., chores), develop a program that modifies these contingencies.
6. Identify activities that the child values and help them set goals to bring activities of daily living closer to valued directions, even with pain sensations (e.g., the draw what's in your heart activity).

7. Help parents address the distress they feel when the child reports or displays pain.
8. Suggest a resource book for families to use for advice on common medical problems.

Value-directed behavior change techniques (as discussed in earlier examples in this chapter) are helpful to children with pain (See Robinson, Wicksell, & Olsson, 2005 for an in-depth discussion). Children will often readily identify valued activities (e.g., having fun with Mom or Dad or being a good helper in the family for a younger child; going to school and doing cool things with friends for an older child). Greco and Dew (2005) developed a technique involving inviting the child to draw a picture of something that really matters to him or her inside the empty space of a heart (the “Draw What’s in your Heart” exercise). The BHC can look at the heart and ask the child if she or he wants to do more things like those in the heart picture, even if there is pain involved. The BHC may also help the child defuse from the pain by suggesting that the pain sensations and thoughts sometimes act like bullies and try to boss the child around and that the BHC can help the child learn to cope with bullies without fighting them. The BHC can also coach the child to request parental support for not getting bullied by thoughts about pain and for doing more things like those in his or her heart. Some parents may need help with learning how to provide timely reinforcement when the child exhibits new behaviors. Various books may help children and parents cope more successfully with pain and other discomforts (e.g., fear, anger, etc.). Greco and Dew (2005) compiled a list of books to support better coping in children with pain complaints; these are provided in Appendix B. Many of these books can readily be integrated as part of the behavior change plan generated in the BHC consultation.

Another BHC intervention for this group concerns meeting the information needs of parents, particularly those who are new parents and lack both information about childhood pain and strategies for responding to pain behaviors. There are a number of books available that provide information on treating common minor health problems at home without medical assistance, and we recommend that the family purchase a resource book if they don't already have one (See, for example, Smyth, Haas, & Jones, 1995). These books usually help readers to decide if medical care is necessary. The BHC may suggest that parents develop a question that helps them talk with their child about whether or not medical care is necessary, such as "Do you think this is a case for Dr. Mommy (or Daddy) or for Dr. X (PCP)? If it's a Dr. Mommy case, this is what we will do . . . ." We also advise parents to explain that if it is a Dr. X (PCP) case, medical care is sought during school hours, and the child is too ill to return to school, the child will need to remain in bed with television and game devices off for the remainder of the day while the parent delivers the medically advised treatment. Having a planned way of communicating with a sick child can help parents avoid reinforcing somatic complaints and sick behavior and to instead provide support for healthy functioning.

PCP Teaching Points Concerning Young Children with Aches and Pains. PCPs are likely to experience more success with children with pain complaints and their parents when they include an evaluation of life stresses in their evaluation and apply the concepts of value-driven behavior change. One of our PCP colleagues recently participated in the making of a video about his experience with the PCBH model. When asked about the impact of BHC services on his clinic, he said that the greatest change had been in his practice style. He explained that, "When I see a child with headaches, my first set of questions include those about stress at home and school, and overall I am much less likely to refer for neurological or

other specialty consults during the process of treating children with pain complaints.” The idea of helping patients function with pain appeals to PCPs. They support it more heartily after patients learn (often from BHCs) active strategies for coping with pain (such as those suggested in Table 9.8) and even more when the BHC explains that behavior changes made in the service of values are more durable than behavior change made in a goal-setting process devoid of a values context. We also recommend that PCPs explore sleep when exploring routine pain complaints, as inadequate sleep is common (particularly among adolescents) and may predispose them to experience of chronic, low grade pain.

Table 9.8

PCP Teaching Points Concerning Young Children with Aches and Pains

1. Suggest that PCPs include questions about stress at home and school when exploring common pain complaints, such as headaches and stomachaches.
2. Suggest that PCPs also explore sleep when evaluating pain complaints.
3. Encourage PCPs to tell patients that some pain is normal and that it is important to find active coping strategies for addressing it (e.g., breathing techniques, self-message or message from others, exercise, relaxation activities, etc.)

### CHILDREN WITH SOCIAL PROBLEMS

While there are empirically supported interventions for teaching young children how to be socially and emotionally competent, most children do not have the opportunity to participate in them. Therefore, BHCs see many children who lack social skills, including shy children, bullies and their victims. When children like Paul come in with these types of social deficits,

BHC interventions can help build better social integration with associated rapid improvements in functioning.

Paul: They're mean to me at school.

Dr. Marks referred this 10-year-old, fourth grader for a consultation concerning social problems at school. Paul's sister had come for a consultation with the BHC several months prior, and the parents asked to see the BHC for recommendations on how to respond to their son's current problems. The parents observed that Paul was experiencing more fatigue, irritability, and worry in response to the stress of being bullied at school. Figure 9.1 displays a copy of the "SOAP" note from the initial BHC consult and Figure 9.2 of the follow-up BHC consult.

SUBJECTIVE: Dr. Marks refers this 10-year-old, fourth grader for a consultation concerning school problems and related fatigue, irritability, and increased worry, which started after several bullying incidents at school. Patient indicated that he usually resists being bullied, and that the bullying tends to escalate when he resists. The two students bullying patient started this two years prior, and one recently threatened to slit patient's throat. The parents are working with school personnel on this issue. Patient is doing well in school academically and has a group of friends. He likes to play sports, ride his bike and play computer games.

OBJECTIVE: Pediatric Symptom Profile total score is twelve, and this suggests psychosocial dysfunction for a Mexican American child.

ASSESSMENT / PLAN: Patient wants to learn more about self-discipline and making

intentional choices when responding to stressful interpersonal exchanges. We talked about an image of letting balls go by versus trying to catch all of the balls and return them. Additionally, we generated a list of ways to respond to bullying (e.g., walking away, ignoring, looking for win-win solutions, etc.). Patient's mother agreed to explore his participation on a football team and / or a karate class over the coming summer, as he would like to be more physically active. I recommend Dr. Marks support patient's efforts to learn new ways to respond to bullying. Patient will come for one additional follow-up with me in 2-3 weeks.

Figure 9.1

SOAP Note on Paul's Initial BHC Consult

**SUBJECTIVE:** This Dr. Mark's patient returns with his mother for follow-up of his consultation concerning fatigue, irritability, and worry in relation to school social problems. Patient has been experimenting with new ways to respond to bullying, and his relationships with the students that were bullying him are much better. In fact, some of the bullies are now his friends. He plans to go to Boy Scout Camp this summer and to work on his swimming badge.

**OBJECTIVE:** Pediatric Symptom Profile score is 11, which is below the cut-off of 12 for significant psychosocial dysfunction for a Mexican American child.

**ASSESSMENT / PLAN:** All symptoms targeted in the consultation are improving.

Patient plans to continue using a variety of strategies to address bullying and making and maintaining friends. Patient will see Dr. Marks in two months for support of these behavior changes.

Figure 9.2

SOAP Note on Paul's Follow-up Consult

BHC Intervention Possibilities for Children with Social Problems. Paul's case example demonstrates the value of brief BHC services aimed at improving the child's flexibility in responding to challenging social circumstances. With a few more tools in his bag of social tricks, his distress level dropped and he actually made enemies into friends. This intervention focused on helping Paul develop some rudimentary social skills, although it probably served to allay some of his parents concerns as well. As can be seen at the top of the list in Table 9.9, teaching social skills is a first order BHC intervention for children with any type of social problem. Additionally, practicing relaxation and mindfulness skills both in session and at home empower the child's ability to apply these skills successfully in real-life circumstances. Such skill training is also helpful to shy and socially anxious children.

Table 9.9

BHC Intervention Possibilities for Children with Social Problems

1. After completing a functional analysis on a social situation that illustrates the social problem, teach social skills to remediate deficits.
2. Teach mindfulness and relaxation skills so that the child is able to be present and choose a strategy for responding, rather than simple react.

3. Use role-playing to provide skill practice, and enlist parent support in home-based practice.
4. Enlist support from teachers, such as preparing bullied children to be seen as competent by teaching them a skill that they can demonstrate well before the class (e.g., how to build a model airplane or make an origami bird).
5. Start a workshop or series of classes that draws from materials such as the Incredible Years Dinosaur Social Skills and Problem-Solving Child Training Program.

While Paul required very little in the way of intervention, other children with social problems may benefit from brief co-management by the BHC and PCP. Children, like Paul, have relatively strong social skills and are more resilient to bullying. Children with less well developed social skills, particularly those with learning disabilities, may experience more harm from bullying and may respond by withdrawal, isolation and loneliness (Asher & Paquette, 2003). For these children, the BHC will need to provide more skill training in concert with the PCP and to consider placement in social skill training groups in the community. Additionally, teachers may be willing to work with the BHC and PCPs to improve the social status of these children in the classroom. This may involve giving the child a socially desirable asset outside of the class situation (e.g., demonstrating the steps in a planned science or art project) that the child can use to generate social approval in the classroom (e.g., knowing in advance the steps of a “cool” science experiment and leading the class in the experiment, passing out some type of reward, such as candies or tokens).

The BHC may develop primary care workshops and classes that foster social competence, as the lack of remediation of social skills early in a child’s school experience puts

him or her at risk academically and psychosocially. Socially anxious and bullied children may be more at risk for developing symptoms of depression, and young bullies may blossom into children with conduct disorders. The Incredible Years Dinosaur Social Skills and Problem-Solving Child Training Program (Webster-Stratton, 2001) offers a curriculum for teaching young children how to work with their emotions, take perspective, make friends, communicate, manage anger, solve interpersonal problems, and succeed at school. This excellent program has been adapted for use by preschool and elementary teachers as a prevention curriculum, and it could certainly be adapted for primary care implementation. (See Webster-Stratton & Reid, 2004 for information about this curriculum and its efficacy.)

PCP Teaching Points Concerning Young Children with Social Problems. PCPs, particularly those with a more biomedical orientation, may not routinely ask about a child's social situation when the child presents with symptoms of anxiety and/or depression. However, most children with symptoms of anxiety and depression do have social problems and coming up with solutions may result in improvement to symptoms of depression and anxiety. As suggested in Table 9.10, teaching PCPs to assess for social problems whenever a child presents with psychosocial issues is an effective strategy for identifying children with social skill deficits who are at risk for co-morbid psychological and academic problems. Many PCPs are quite savvy regarding the importance of social skills, so the BHC will need to formulate an individual plan of attack for each PCP. Inviting a PCP with less training to observe a workshop or class series on social skills provides an "innocuous" learning opportunity, as does sharing a list of children's books that address common issues related to social skills (e.g., sharing, bullying, being friendly, etc.). Having a list of books to pass along to parents may help PCPs to

consistently ask about social skills when children present with various symptoms of psychosocial dysfunction.

Table 9.10

PCP Teaching Points Concerning Children with Social Problems

1. Teach PCPs to explore social concerns when children present with possible symptoms of depression and anxiety, such as fatigue, sleep problems, and excessive worry.
2. Invite PCPs to co-lead or sit-in on workshops or class series on social skills lead by the BHC.
3. Provide a list of children's books that address common social skill topics.

### CHILDREN RECOVERING FROM TRAUMA

The BHC will receive many referrals that involve helping children and their families recover from trauma. In these consults, the primary focus is on helping the child and family increase their general functioning, and the BHC will need to listen to the child and family members carefully to hear exactly how this needs to happen. Mary's case example illustrates this process of strategic listening that then puts the BHC in a position to support a rapid return to functioning.

Mary: I am going to have a baby.

Dr. Rose referred this 13-year-old patient and her parents for a consultation concerning an unplanned pregnancy. Mary was seven months pregnant, and the pregnancy was the result of rape by a cousin that was no longer in the area. He had threatened Mary's life if she told

anyone about the rape, so she had not revealed the trauma or her pregnancy until her parents sought medical care for her in the seventh month of her pregnancy. Mary told the BHC that she wanted to have the baby, be a good mother, and return to school full time as soon as possible. She was afraid that she might be too small to give birth and feared the pain of childbirth. She hoped that she could grow up and study to become a doctor, like Dr. Rose, as her care had been very helpful to Mary. She had a strong academic background, and the BHC encouraged her aspiration and told her about job-shadowing opportunities for high school students in the clinic. The initial consultation focused on Mary's main concerns: preparation for birth (the reason for referral) and being able to return to school. The BHC taught her a breathing technique to practice to improve her relaxation skills and answered specific questions concerning the process of giving birth.

At the end of the visit, she briefly mentioned that she worried about how her problems affected her parents, and the BHC offered to speak with each of them to provide ideas for coping. The BHC saw Mary's mother alone for a few minutes and explained the breathing technique she had taught Mary. The mother agreed to attend birthing classes with Mary and to support her expeditious return to school by caring for the baby while Mary attended classes. The mother explained that she felt sad and also voiced concern about how angry and frustrated her husband felt. The BHC saw the father alone for a few minutes, and he said he felt that he had failed to protect Mary. The BHC listened and suggested that he had done many things right as a father and that most parents want to offer their children more protection than they often actually can. The BHC asked him how he thought he could protect Mary now, and he indicated that he could take care of her and the baby and support her return to school. He also indicated that he would take the lead in working with law enforcement officials. During the remainder of

the visit, the BHC helped the father plan how he was take a central, protective role in helping Mary and others in the family recover from this painful event. He left with a plan to talk with his daughter, wife and other children about his desire to protect and care for them now and in the future. He also agreed to be a leader in helping the family care for Mary and her baby as the birth approached and afterwards.

The BHC discussed the plan with the Dr. Rose and emphasized the extent to which Mary saw her as helpful. The relationship between Mary and Dr. Rose, already strong, grew stronger, and this further enabled Mary to face childbirth with confidence. After birth, Mary maintained contact with her PCP, who had become not only her PCP but her role model. Mary came for two follow-up visits with the BHC, and at these visits, the BHC discussed approach versus avoidance coping styles and coached her on problem solving skills. The BHC focused on strategies to increase her attachment to the baby and helped her make a plan that allowed her to continue nursing while attending school part-time. Lastly, the BHC helped her to address hurtful comments from classmates concerning her being sexually active and being an unwed mother.

BHC Intervention Possibilities for Children Recovering from Trauma. There are a variety of interventions that are useful to children recovering from trauma, including efforts to bolster child and family resources for coping after a traumatic event. Mary's case example illustrates how important it is for the BHC to focus on the referral question first, and then move onto other behavioral goals if they seem indicated. Mary wanted information to allay her fears, skills for preparing for birth, and support for returning to normal childhood activities, such as attending school. The BHC addressed these needs immediately and then incorporated Mary's values to create a long term life plan that was big enough and desirable enough (i.e., becoming

a doctor) to justify her current struggles. Mary knew that her parents were upset; she asked the BHC to help them. The BHC's rapid response helped build Mary's sense of being able to cope with her circumstance. The BHC also taught Mary problem-solving methods in follow-up appointments, which she applied to social situations at school and to issues related to sorting out being a teen age parent.

It is important to highlight what the BHC did NOT do with Mary or her parents, as this reflects the pragmatic and practical side of BHC work. The BHC did not engage Mary or her parents in clinical interactions about the repeated instances of assault that she had experienced (when her parents were away from home). Beyond uncovering enough information to know that the patient and her family were safe and that law enforcement officials were involved, there was no exploration of the trauma per se. The BHC did ask the father to continue to take the lead in working with police, as this functioned to protect Mary and to provide a sense of vindication to the father.

As indicated in Table 9.11, a top priority in using the tools of functional analysis with trauma victims is that of identifying the child's concerns. Mary's concern was that she was physically small, that she was not moving along in her school curriculum with her friends, and that her parents were upset. She was not concerned about intrusive images, nightmares, etc. The plan resulting from the initial consultation addressed her immediate concerns and directed support to her parents. The BHC helped the parents sort out their post-trauma roles so that they could offer maximum support. The mother came to terms with being a mother for and with her daughter, and the father developed a strong stance for being a protective father in the present moment and in the future. Numerous cognitive behavioral techniques may be helpful to traumatized children, and the choice to use them revolves around their relevance to the goal of

helping the child and family recover optimal functioning. Possibilities include interventions such as relaxation training, anger management, personal assertion, developing an observer self, learning to focus on the present moment, and problem solving skills.

Table 9.11

BHC Intervention Possibilities for Children Recovering from Trauma

1. Identify patient's current need and center the functional analysis on ways to meet this need.
2. Emphasis child (and parent) strengths and resources in planning.
3. Help the child (and parents) sort out roles that may become confused by the trauma.
4. Teach problem solving skills to use in addressing current and future problems (that may relate to the consequences of the trauma).

PCP Teaching Points Concerning Children Recovering from Trauma. Many PCPs feel overwhelmed when learning that a child has experienced trauma. PCPs may want to offer patients comprehensive specialty treatment, and, for most trauma victims, this is not—for a myriad of reasons—feasible. Crisis services are strained by lack of funding, and geographical and economic barriers loom large for many children and their families. PCPs may also struggle with blaming themselves for not detecting on-going traumatic experiences earlier, particularly in the case of sexual or physical abuse by a family member. As suggested in Table 9.12, the BHC needs to explain the process of dissociation and the survival value of blocking recall or denying the trauma. PCPs may assume that trauma patients always need to discuss the trauma in detail in order to recover. In contrast, many victims don't want to delve into the trauma and instead want to regain a sense of being in control of their lives. Available evidence suggests

that a single session of individual debriefing post trauma is not associated with a subsequent reduction in the likelihood of post traumatic stress disorder (PTSD), nor does debriefing reduce self reported psychological distress. In fact, one year follow-up data suggest that the risk of PTSD may be significantly GREATER for individuals who receive such service (Rose, Bisson, Churchill, & Wessely, 2005). Finally, it is important that the PCP understand the potential inherent in a strong patient-PCP relationship. Many child trauma victims identify strongly with the PCPs that help them. This identification process is best supported by PCPs who see the child as resilient and capable, rather than damaged and “broken” by virtue of exposure to the traumatic event (s).

Table 9.12

PCP Teaching Points Concerning Children Recovering from Trauma

1. Encourage PCPs to refer children recovering from trauma to the BHC for consultation, as this may be the only BH service they receive or the one that is most available over the course of the decade following the trauma.
2. Listen for “hints” that the PCP blames himself or herself for failure to detect trauma resulting from on-going abuse and provide reassurance.
3. Explain the process of dissociation and the survival value of a child’s being able to block recall or deny the trauma.
4. Inform PCPs that a single session individual debriefing does not prevent onset of post traumatic stress disorder nor reduce psychological distress and in fact may put the patient more at risk.
5. Encourage the PCP to see the child trauma victim as resilient (and not as “damaged

goods.”)
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## CHILDREN WITH ADHD

While children may have disabilities (such as ADHD, learning disabilities, and speech delays), their lives remain workable when they have the skills to make and maintain friendships and illicit positive regard from their parents and teachers. Estimates suggest 3-6% of children are affected by ADHD nationwide (Hibbs & Jensen, 1996), and since most children with ADHD receive care exclusively in primary care setting, BHCs will have many opportunities to assist ADHD children and their parents. Samuel’s case example illustrates the potential role the BHC can play in supporting diagnosis, bringing behavioral interventions to the youth and his or her family, and evaluating treatment response.

Samuel: He’s intelligent, but . . . he interrupts . . . argues . . . .

Dr. Davis referred this 13-year-old, 7<sup>th</sup> grader for a consultation concerning delays in developing academic skills, attention problems, and interpersonal problems. Historically, Samuel had struggled academically, as he had been slow to develop writing skills. Now in sixth grade, he was failing all classes and having social problems. His parents came with him to the initial consultation, bringing a note from his teacher that stated, “. . . very intelligent . . . always full of information and willing to contribute to discussions, but interrupts other students . . . rarely turns in written work . . . argues quite a bit with other students . . . recently crawled under his desk and cried after receiving his grade on a test.”

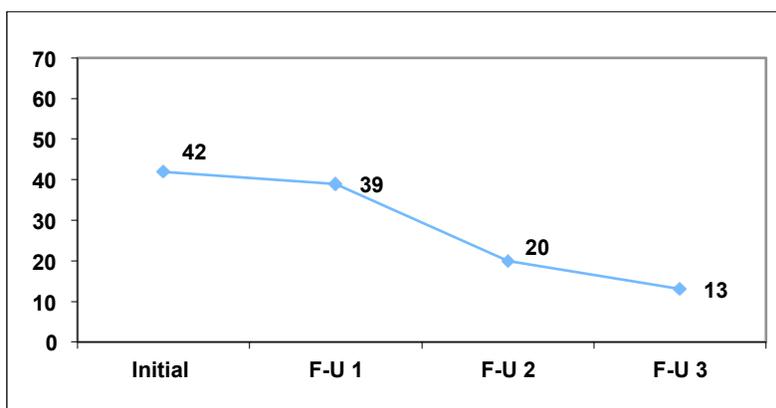
In the initial consult, Samuel indicated that he enjoyed learning about computers, science and math and that he wanted to play a sport, such as soccer, but could not due to his grades. The BHC initiated an objective assessment for ADHD by giving his parents a

questionnaire for them to complete and a second one for them to ask the teacher to complete. Additionally, the BHC encouraged the parents to locate a sports team for Samuel that week and to support his efforts to complete homework by staying in the same room with him while he worked (his request) and allowing him to listen to rock music as he worked. The parents also agreed to stay in touch with teachers about homework assignments through e-mails.

The BHC saw Samuel and his parents for three follow-up consultations over a two-month period, and Figure 9.3 shows a graph of his Pediatric Symptom Checklist (PSC) Scores at the initial and follow-up visits. His parents returned the ADHD questionnaires at the initial follow-up and results suggested a diagnosis ADHD was warranted. The BHC worked with Dr. Smith during the consult with Samuel, and he initiated a medication trial, as Dr. Davis was out of the clinic. Samuel reported that he planned to wait to join a sports team until he had practiced for a while with his Dad. At the second follow-up, Samuel and his parents indicated significant improvement, and this was consistent with data provided by his teachers. However, reports indicated Sam continued to have problems with interrupting and talking excessively so the BHC conducted a functional analysis on these behaviors and helped him develop a self-control program. Specifically, Samuel agreed to monitor his urges to speak out in his first period class and to experiment with using a breathing technique on every other urge. This involved using “belly” breathing and stating “here” on the inhalation and “now” on the exhalation. To remember to use five here and now cycles for every other urge, he would keep his left hand under his left leg, and when the hand came up he would remember to start the breathing exercise. Samuel identified this as his breathing cue as he tended to use his hands to gesture when he spoke. Dr. Davis was not in the clinic at the second follow-up, so Dr. Jones provided a medication refill. The BHC recommended a follow-up visit with Dr. Davis to

discuss medication issues, including making a decision about whether to continue medication use over the upcoming summer.

At Samuel's last follow-up visit with the BHC, his mother reported very positive feedback from his school counselor concerning his grades, which were now in the A, B, and C range. He had made some head-way with curbing his interrupting behavior and excessive talking in his first period, and it seemed to be generalizing some to other classes. His parents saw improvement at home, even though they did not have him take the medicine on weekends. The BHC encouraged the father to help Samuel improve his skills for playing a team sport over the summer and to become involved as a volunteer for the Sam's team. This would allow the father to detect social skill training needs and later coach Sam on specific skills needed to work successfully in a group.



Note: PSC total scores range from 0 to 70; a score 28 suggests that Samuel is experiencing significant psychosocial dysfunction.

Figure 9.3

#### Graph of Samuel's Pediatric Symptom Checklist Scores

BHC Intervention Possibilities for Children with ADHD. Sam's case example demonstrates the important role the BHC plays in making a diagnosis and evaluating a

medication trial based on objective information from parents and teachers. Additionally, the BHC checked on side effects, supported activities that strengthened relationships between the child and parents, and helped Sam develop skills for inhibiting urges to interrupt others in class. This example also illustrates the important role that the primary care team plays. Since Dr. Davis, Samuel's PCP was out of the clinic at the time of his second and third contacts with the BHC, another PCP covered for him. As a rule of thumb, the BHC should seek advice from the PCP that is covering for an absent PCP when there is a question concerning use of medication, as such might save a visit and might result in more timely changes to the treatment plan. The factors to weigh include the potential benefit of a PCP starting or changing a medicine now (such as when a child is having serious problems in school) versus the risks of not having the patient's own PCP directly involved in medication decisions. The risks associated with starting or changing medicines without the direct involvement of patient's PCP are substantial when either the child or parents are ambivalent about using medications. In those cases, it may be best to have the child and his family schedule with the child's PCP, even though changes involving medication are delayed.

As can be seen in Table 9.13, there are many possible interventions that a BHC can offer beyond assessment and evaluation of medication trials. BHC interventions may address social skill deficits and relationship problems with parents and other family members. One of us (JR) offers group visits for ADHD children and their parents and provides parenting instruction specific for ADHD children as a part of the monthly or quarterly group visit. There are materials available for the BHC to use in developing ADHD specific parent training programs for group visits, classes, or workshops (cf. Anastopoulos, Barkley, & Shelton, 1996).

There are also numerous books that may help parents be effective social coaches for children with ADHD, as well as with learning disabilities (Giler, 1998).

Other possibilities for BHC interventions involve use of resources outside the clinic. For example, many children benefit when BHC helps teachers and parents start a daily report card program. The Vanderbilt Tool Kit website offers an excellent handout to support this type of program. Some children will continue to make exceptionally slow progress in acquiring academic skills after a medication is started, and some will have specific deficits (e.g., difficulties with writing, reading, or math). The BHC work with the PCP in making a decision concerning whether to write a letter to the school recommending that the patient receive individualized testing to assess the need for a special educational program. Additionally, various universities offer summer camp programs for children with ADHD, and we recommend that the BHC stay informed about these, as they offer children with ADHD unique opportunities for social and academic skill remediation.

Table 9.13

BHC Intervention Possibilities for Children with ADHD

1. Assist the PCP with administering and interpreting questionnaires that help establish the diagnosis and that evaluate medication trials (when medicines are started).
2. Evaluate medication side effects.
3. Assess social skills and social status and provide remediation as needed.
4. Assess relationship with parents and plan activities to improve relationship quality if indicated.
5. Teach parents to function as social skill coaches.

6. Recommend books to parents concerning parenting children with ADHD.
7. Co-lead group visits for children with ADHD and their parents and include parent training as part of the visit.
8. Facilitate development of daily report card programs to improve rate of homework completion and/or other behaviors important to academic and social success.
9. Advocate for educational testing if a child appears to need a special education program in order to acquire academic skills at a rate consistent with their intellectual capacity.
10. Refer children to ADHD summer camp programs for social skill remediation.

PCP Teaching Points Concerning Children with ADHD. PCPs will readily adapt a consistent approach to assessment and monitoring of core ADHD symptoms, if the BHC does the “leg work” and provides the evidence base for using these assessment systems. Some community school systems are adopting comprehensive systems, such as the Vanderbilt, which is free and readily available on the Internet. This facilitates communication between clinic and school staff and saves time. Most PCPs will pass along a reading list to parents with interests in such, so this is a worthwhile endeavor for the BHC. Over time, some PCPs will learn to some of the interventions used by BHCs to remediate social skills and improve parent and child relationships, particularly when they choose to take a group visit approach to caring for children with ADHD. As suggested in Table 9.14, the BHC may encourage PCPs to begin group visits in order to improve their skills with this population (as well as other reasons, which we discuss in Chapter 12). Most PCPs want to see children with ADHD every three months, and the group visit makes this feasible.

Table 9.14

PCP Teaching Points Concerning Children with ADHD

1. Encourage PCPs to use the same ADHD questionnaires as schools in the community.
2. Explain the group visit approach to providing services to ADHD children.
3. Suggest that PCPs refer children with ADHD to the BHC for a discussion of developmental transition issues at the end of middle childhood and again toward the end of high school years.
4. Suggest that PCPs use the BHC to assist adolescents with ADHD who refuse to take medication.

Finally, BHCs may encourage PCPs to refer children with ADHD for BHC consultation visits focused on preparing them and their families for transitions, such as graduation into the middle school. The BHC can help these families adjust their communication and problem solving styles to accommodate the child's growing need for autonomy while continuing to provide adequate structure and support. Some children refuse to take medications at some point in adolescence, and the adolescent that's had a consultation with the BHC focused on preparing for him or her for adolescence may be more willing to review this decision with the BHC. We find that many adolescents will consider taking medicine if offered an opportunity to work with the BHC to see if they can succeed at school without medication. The BHC can teach the adolescent with ADHD strategies for focusing and organizing study time and experiment with these behavioral strategies in lieu of using medicines. Again, employing parent and teacher data, combined with the adolescent's self-report, provides a way to assess the degree of

behavioral control present when medicines are used versus when behavioral strategies are employed. Even if the results of the behavioral experiment are positive, it is advisable to continue monitoring behavioral control at least at monthly intervals for the first year.

### SUMMARY

1. BHCs see many children at a brisk pace in primary care. In fact, 20-40% of a BHC's contacts may be with children and teenagers, depending on the clinic. For most consults, the BHC will need to maintain a focus that includes working with members of the patient's family.
2. Many parents lack skills for parenting, and the ideal time to address their needs is probably when their children are between two and seven. BHCs may use a PCBH parenting protocol to teach basic skills in a 3-session series, provide workshops or classes, or refer to parenting classes in the community.
3. Many children are overweight or obese, and the BHC needs to prepare to assist these children and their families with behavior change. Serving these children and teenagers provides the BHC with opportunities to work closely with other members of the PCP team, such as dieticians and diabetes educators.
4. Pediatric pain is a common reason for referral, and one that requires skillful use of the tools of functional analysis in the context of the family. ACT, along with other CBT strategies, offer potent interventions for improving functioning. Appendix B includes a reading list for parents and children.
5. Many BHC referrals will concern social problems, and unresolved social problems predispose children to development of more significant symptoms of psychosocial

dysfunction, often characterized by symptoms of anxiety and depression. Social skill training works well in the context of PCBH consultation.

6. Primary care is the safety net for victims of trauma, and this is no less true for children than for adults. BHCs can target victim's concerns and use identified strengths to help children and their families resume meaningful lives. BHCs can also provide important information and support to PCPs, particularly concerning the lack of effectiveness of debriefing sessions.
7. Two-thirds of children with ADHD have significant problems with functioning in adulthood, and BHCs can change this statistic by assisting PCPs with diagnosis and interventions, including teaching social skills and helping their parents be more effective leaders in their lives.