

INTERVIEW TECHNIQUES

Chapter 3

To maximize their effectiveness, clinicians need to be skilled in communication techniques and strategies for developing rapport with patients. They need to use age-appropriate, open-ended questions to encourage patients and parents to volunteer information they might not realize is important. They also need to listen actively and respond to emotions to help patients fully disclose what might be happening at home. Used together, these techniques help improve health and adherence, increase patient satisfaction, and reduce provider frustration.

Often, the personal information disclosed by patients and their families may touch on highly sensitive topics, ones that are uncomfortable for clinicians, and potentially painful for the patient or parent. Although difficult to discuss, information about sensitive topics should not be ignored; sometimes it holds the key to the presenting physical problem.

This chapter describes general communication techniques useful in all medical interview situations, as well as techniques most helpful in conversations about sensitive issues with patients and their families.

General Interviewing Techniques

Given the broad goals of the medical interview, it is clear why most clinicians already feel pressed to accomplish a considerable amount in one short interview. The techniques presented here are intended to fit within the constraints of a normal patient visit. Clinicians who routinely use these techniques should, over time, find that interviews are more efficient through early identification, referrals and treatment of psychosocial problems that can result in physical complaints.

The best way to create an accurate and timely flow of information is to create an environment in which patients feel free to discuss anything that might be relevant to their health. Establishing this kind of trust and interaction does not occur in one visit however, placing children without a regular provider at a significant disadvantage. It takes time for patients and parents to view their health care provider

as sensitive and trustworthy. However, clinicians can incorporate a number of techniques into their interviewing styles that will assist them in developing this kind of positive relationship with patients and their families.

establish the parameters of the interview

It is important to explain to patients, especially if they are young or visiting for the first time, what can reasonably be accomplished within the typical pediatric interview. Patients need to be aware that health care visits are a time to bring up any issue which might concern them, or that might be affecting their physical, emotional or psychological well-being, even if it seems silly or trivial. Patients and families may need to be reminded that there is no way for a provider to know something that has not been shared. Clinicians can also explain that while they may not be able to fix every problem, there is assistance for most concerns with time and help from others.

Establish confidentiality: In many cases, clinicians will need to explain this concept. Patients should know that there are many things that will not be shared, but if something is immediately endangering the welfare of the patient, others may have to get involved. Patients should be given time to ask questions about what might fall into each category. With adolescents, confidentiality is particularly important and should be reviewed with the patient when parents are not in the room.

appropriate body language

Even before the clinician ever speaks, patients make conscious and unconscious decisions about how comfortable they feel, based on body language and other non-verbal cues.

One important set of cues involves a receptive demeanor. To increase patients' comfort level and make them feel the provider is listening and available, clinicians should:

- minimize the distance between patient or parent and clinician, such as by sitting next to them rather than across a desk
- establish eye contact with the patient or parent, staying at similar eye level whenever possible
- lean forward, expressing interest and attentiveness, especially when the patient or parent is speaking

Developing effective relationships with patients and their families:

- ***establish parameters of interview***
 - ***no concern is silly***
 - ***review confidentiality***
- ***use appropriate body language***
- ***practice active listening***
- ***develop individualized, achievable treatment plan***

- avoid conveying a sense of being rushed, even if there is very little time in reality
- limit note-taking as much as possible
- avoid interruptions

If there is a need to record information, clinicians should explain to patients or parents that they will be taking notes because what is being said is very important and writing it down helps them to remember. It is also recommended that clinicians should take notes throughout the interview rather than only during expressions of problems, to limit patients' feelings of discomfort and stigma.

effective listening and communication

How questions are asked is more important than what is asked. Clinicians should try to ask questions that allow the patient to set the agenda for the interview and disclose all relevant information or problems. One of the best ways to accomplish this is by asking open-ended questions that must be answered in a narrative fashion rather than with a “yes” or “no.” This allows patients to share their emotional state and provides them with the freedom to address a variety of issues. Above all, clinicians should make sure to speak directly with the patient whenever appropriate and possible, rather than through the parent.

While patients are speaking, clinicians should use *active listening* techniques that encourage patients to express their concerns and needs. Active listening is a technique that allows people to listen without judging, condemning or criticizing, while helping to draw out important information from the speaker (patient/parent). Active listening involves keeping the focus on the speaker, making observations rather than statements of fact, and asking for clarification when something is not clear. Active listening allows the listener to help the speaker think through the options without being too directive - “What options have you considered?” rather than “Why didn't you call a psychiatrist for a consultation?”

A simple but important active listening technique is to use facilitating statements such as “uh-huh” or “I see” or non-verbal encouragement such as nodding. Another technique is to paraphrase what is being said so that patients know they are understood and to encourage further disclosure. Interruptions should be avoided, however, even in the interest of paraphrasing - they are discouraging and many patients will stop speaking rather than risk another interruption.

Active listening:

- **open-ended questions**
- **no judging, condemning**
- **ask questions for clarification**
- **keep focus on speaker**
- **use facilitating statements**
- **paraphrase**
- **"what else is bothering you?"**

Clinicians should not assume that patients are always finished when they first stop speaking. Questions such as “What else is bothering you” can be used to ensure that all relevant information has been shared. As a complete picture begins to emerge, clinicians can gradually narrow the focus of the interview, asking questions about specific parts of the patient’s (or parent's) statements. Factual information can be checked by repeating it back in summary statements.

realistic treatment plans

Once information is shared and emotions are addressed, providers respond by forming a treatment plan and sharing it with the patient and family. Although their language skills may not be as developed, even younger children can have a reasonably sophisticated understanding of problems and treatment options. Especially with regard to psychosocial problems, children often have already developed their own coping strategies with varying degrees of efficacy. Patients or parents should always be asked first how they are dealing with a problem before clinicians suggest their own solutions. Recommendations need to fit the lifestyle and abilities of the patient and their family.

The treatment plan should be expressed in ways the parent and the child can understand: short, clear sentences are best, with frequent pauses to avoid information overload. It can be helpful to repeat key details, asking the patient to repeat them back. The rationale behind each suggestion can be explained so that the patient has a framework within which to understand the different parts of the treatment plan. Clinicians should also give the patient or parent an opportunity to verbalize how each aspect of the plan might work and adjust the plan, if necessary, to fit the needs of the family.

Addressing Sensitive Topics

There are five basic priorities for the child health care provider regarding sensitive topics:

- screen for and assess problems on a regular basis
- ask about problems when it seems appropriate
- acknowledge problems when they are disclosed
- be supportive and helpful to patients and their families
- do not feel responsible for every aspect of a family’s problems

Achievable treatment plans:

- ***ask what patient is already doing***
- ***make sure plan fits patient's and family's ability to comply***
- ***explain plan to patient in developmentally appropriate language***

Priorities for clinicians:

- ***screen routinely for problems***
- ***ask about problems, when indicated***
- ***acknowledge problems once disclosed***
- ***be supportive to patient and family***
- ***don't feel responsible to solve problems alone***

When patients have numerous problems, clinicians may:

- **need to work with patients to prioritize concerns**
- **require several visits to complete their initial assessment**

Screenings:

- **brief**
- **first step in investigating a sensitive problem**
- **not a diagnosis**
- **indicate need for further assessment**

Assessments:

- **comprehensive**
- **conducted by trained professionals**
- **rely on special tools**
- **can last up to three hours**

While the interviewing techniques discussed above are appropriate for any medical encounter, there are special techniques that can be used to introduce and discuss sensitive topics.

Unfortunately, there is rarely sufficient time available to fully discuss all the sensitive issues that might affect a family. When there are a number of interrelated problems, clinicians may need to work with patients and their families to determine which concerns merit priority attention. In fact, it may take several visits over a period of time to complete the initial assessment of patients and families who are coping with complex medical and psychosocial problems. Even when all the issues are out on the table, the typical 10-15 minute pediatric interview often does not allow for in-depth discussion of these kinds of complicated problems. Despite time limits, clinicians can still be helpful. Introducing sensitive subjects and making referrals to specialists who do have the time is both important and very helpful to patients.

screening vs. assessment

There are two types of interviews in which health care providers specifically seek information about sensitive topics - screenings and assessments. The *screening interview* is usually 5 - 20 minutes in length and is the initial step in identifying a problem. A positive finding in a screening interview does not constitute a diagnosis, but it does identify a need for further investigation. The screening interview is conducted within the scope of a normal office visit, and may benefit from the use of special screening instruments.

Once a potential problem has been identified, further information should be gathered through an *assessment interview*. An assessment, as the name implies, is more comprehensive and is generally administered by a specially-trained professional. Specialists conducting assessments may rely on any of a variety of tools to gather information, and an assessment interview can last up to three hours, depending on the presenting problem and the specialist.

Because most pediatric health care providers are not specialists who routinely conduct these kinds of assessments, the screening interview is the focus of the remainder of this chapter. In the pages that follow, the reader will find practical techniques that encourage the discussion of important health-related information. Information is also included

regarding appropriate responses and possible next steps for providers.

indicators of problems

Patients and/or family members may exhibit or comment on certain signs or symptoms that might indicate a need to probe for possible psychosocial problems, including:

- unkempt or inappropriate clothing
- unexplained burns or bruises
- difficulty in making appointments, or appointments that are casually broken or forgotten
- recurrent patterns of vague somatic complaints, such as headaches, abdominal pain, sleep disorders or musculoskeletal complaints
- unwillingness to participate in spontaneous play
- numb or frozen affect
- complaints of intrusive memories or flashbacks
- distractibility or hypervigilance
- abusive behavior towards peers and siblings
- reports of behavioral or emotional problems
- recurring episodes of apparent accidental trauma
- reports of school difficulties or changes in relationships with peers
- other reports of family dysfunction

When clinicians observe any of these signs, they should follow up with appropriate questions, specifically noting the reason for their concern.

the basics of screening interviews

One of the most difficult tasks in addressing sensitive topics during the medical visit is bringing them up. The best way for clinicians to avoid awkwardness is to routinely include a series of standard related questions into their interview protocol. Questions can be prefaced with the statement, "I ask these questions of all my patients."

Screening for psychosocial problems should take place throughout the duration of the patient/clinician relationship. If all of the regularly scheduled health maintenance visits that occur from birth to age 18 are considered, there are more than 20 opportunities for screening, early

Indicators of problems

- **child**
 - **physical**
 - **emotional or affect**
 - **behavioral**
- **family**
 - **physical**
 - **emotional or affect**
 - **behavioral**

- ***Clinicians should incorporate questions about psychosocial issues into their regular interview protocol. Prefacing the questions with the statement, "I ask these questions of all my patients" reduces stigma and discomfort.***

PANDORA'S BOX

- ***Clinicians should routinely ask questions of both parents and patients, even when the patient is an adolescent.***

Routinely questioning patients about psychosocial issues:

- ***alleviates discomfort***
- ***reduces feelings of threat***
- ***allows clinicians to safely pursue issues of concern***

With young teens and adolescents, clinicians may ask the parent to leave the room briefly. If the parent objects, the clinician might:

- ***explain that it is part of the clinician's routine to speak alone with patients***
- ***explain that the parent will have a chance to speak with the clinician again afterward***
- ***ask why the parent is reluctant to leave***
- ***elect to not persist in pursuing a conversation alone with the patient***

identification and intervention for patients coping with sensitive family problems.

Children are not the only ones who should be asked questions - parents should also be considered sources of information about sensitive topics. If the child is very young, of course, the clinician will screen for problems through the parent. However, even parents of older children should be queried as part of the regular health visit. A good way to initiate the conversation is to say "Having teenagers can be challenging. How is it going for you?" Asking questions routinely of both children and parents gives clinicians additional information, alleviates some discomfort about broaching specific topics, makes concerns seem less threatening and allows providers to pursue potential concerns without putting the child or adolescent in physical or emotional danger.

talking alone with the patient

With young teens and adolescents, parents may be asked to leave the room for a few minutes, with a brief explanation that the clinician likes to have some time alone to talk with his or her patient directly. Parents who express concern about what will happen in their absence can be told that the clinician prefers to talk with patients alone as a way to strengthen the provider/patient relationship and to get a sense of how the patient is doing from his or her own perspective. If a parent is reluctant to leave, the clinician can indicate that he or she will get together with the parent again to discuss any concerns after the child is examined (in the presence of a medical chaperone) and interviewed.

If a parent still refuses to leave, health care providers have two options. If the clinician feels comfortable with the parent, confident that the response will be manageable, and truly concerned, he or she might say "You seem very reluctant to leave the room and I am not sure I understand why. Could you help me to understand your reasons?" While the most typical response to this query is "I think my child needs or wants me to be nearby," it is also possible that the parent will provide a hostile, angry response. In this case, clinicians will need to handle the parent's anger and consider it a red flag for a possible problem. The other option is to not persist in pursuing an interview alone with the child and make a notation of the situation in the chart, for follow up at a later appointment.

developmentally-appropriate interviews

In any discussion with a patient, questions and environment should be developmentally appropriate.

Prenatal Visit: At a prenatal visit with parents, a clinician might ask about both a family's strengths and weaknesses, bringing up common family concerns such as parental substance abuse, conflict, and family violence. Focus should be maintained in these conversations on the responsibility of parents as role models, and the effects of parental behavior on children. It may be less threatening for clinicians to begin by asking if there were problems in the parents' families when they were growing up, rather than focusing immediately on the parents' current behavior. One way to preface these kinds of questions might be "Now I'm going to ask you about patterns that can run in families and have an effect on children's health."

Investigating current parental alcohol and other drug use and family violence allows clinicians to explore potential risks to the fetus such as Fetal Alcohol Syndrome/Effects, *in utero* exposure to drugs, and even harm inflicted by a battering partner and provide health education around these areas. In addition, by exploring these issues, clinicians begin to establish themselves as professionals interested in the well-being of the entire family, and as a source of referrals and information should problems develop in the future. When asked appropriately, these questions help establish a tenor of openness and lack of judgment on the part of the clinician.

Infants and Toddlers: With infants and toddlers, who lack sophisticated comprehension and language skills, the clinician will speak directly with the parent, rather than the child, asking basic questions to ascertain the situation at home. A good way to begin an interview with a parent might be "How are things going for you?" When either the parent's verbal response or body language indicates unhappiness, depression or discomfort, it is useful to make further inquiries. Clinicians should also carefully explore developmental problems that might be related to family problems.

Again, an open atmosphere, free of judgment is essential for parents to feel comfortable being candid about what might be happening at home. For example, clinicians might say "People handle stress in different ways. Some people exercise, some people sleep, some smoke cigarettes, drink

Working with parents at a prenatal visit:

- *parents as role models*
- *effects of parents' behavior on children*
- *begin with questions about parents' own families growing up, rather than current behavior*
- *routinely ask questions about stress and psychosocial issues*

Working with infants and toddlers:

- *watch parents' affect*
- *ask parents how they are handling the stress of parenting*
- *ask about child's strengths and weaknesses*
- *routinely ask questions about psychosocial issues*

alcohol to relax or use other drugs. Some people eat more, others tend to get angry and hit things or people. How are you handling it?"

Parents might also be asked:

- What about your child's behavior makes you feel particularly frustrated? Proud?
- How do you deal with these situations?
- How does your partner deal with these situations? Is this different from your own response?
- How do you and your partner deal together with these situations?

Another option is for parents to be asked questions directly, such as "What happens when you and your spouse argue?" or "Does anybody ever hit in your family?"

These same types of questions can be asked of all parents, regardless of the age of their children.

Working with pre-school children:

- ***address comments to patients and to parents***
- ***with children***
 - ***use short, clear sentences***
 - ***repeat details***
 - ***anchor the past with specific events***
- ***with parents***
 - ***health education***
 - ***information gathering***
 - ***routinely ask questions about stress and psychosocial issues***

Pre-School Children: While pre-school children are more articulate than toddlers, they still have a poor sense of time, and may have difficulty with questions that refer to past events. Even five and six year olds, who have a stronger grasp of past tense and can recall and report events will benefit from the use of short, clear sentences and frequent pauses. Key concepts can be repeated several times, and children might be asked to repeat these details back to make sure everything is understood. It can also be helpful to anchor the past with specific events, such as "Has this happened since your birthday? Thanksgiving?"

Conversations with parents should include relationship building, information gathering and health education. In addition to questions about family problems, the provider should talk a little to parents about how common family problems, such as domestic violence or parental substance abuse can affect parenting decisions, exacerbate stress and marital problems and create a potentially unsafe home environment and poor role model for children. If a parent has already made changes in these areas, the clinician should give the parent plenty of positive reinforcement for their effort. Routinely screening for these kinds of problems allows providers to raise important concerns and give feedback to parents, and further establishes their willingness to discuss these issues at a later time, if needed.

School-Aged Children: As children age, the communication process becomes more direct. In addition to general discussions with patient and parent, when appropriate and possible, providers can also request to speak briefly with patients alone (often starting with the onset of puberty), without the presence of their parents. With younger children, play can be used as a communication tool, allowing for a variety of techniques or approaches for information gathering. Because imagination is such a dominant facet of children at this age, an effective screening question might be to ask children to pretend that they have three wishes. Of course, their responses might focus more on a toy or athletic skill, but some creative probing can often elicit more information about psychosocial concerns.

Clinicians should focus educating children as well as parents. In fact, it is well-documented that health care professionals are highly accepted as an expert source of health information (Hedrick, 1993; Croft, 1993). Questions initially might focus on less threatening topics such as school, friends, physical activity, affect, ambitions, and dietary patterns. For example:

- How do you spend your free time?
- What kind of sports do you play?
- What do you do with your friends?
- What did you have for dinner last night? The night before?

As the conversation becomes more comfortable, the clinician can move into more sensitive areas such as tobacco, alcohol and other drugs; parental substance abuse; sexual activity and violence. Of course, some of these questions will not be appropriate for younger children. However, clinicians should not assume that these concerns are limited to older teens. There is a substantial literature suggesting that these behaviors are prevalent among children as well.

A non-threatening way to introduce problems such as substance abuse or domestic violence is to ask how alcohol, drugs, fighting and violence are being talked about in school or at home. By asking specifics about what is being taught, clinicians can assess whether or not key messages are being delivered. It can be helpful to ask children if they ever talk about these problems with their friends, if they have ever been exposed to these problems, and what they understand about why people are involved in these activities.

Working with school-aged children:

- ***use play and imagination for screening and conversation***
- ***health education for parents and children***
- ***begin questions with those that are least threatening (school, free-time, diet, friends)***
- ***routinely ask parents about stress and psychosocial issues***
- ***ask children how violence, alcohol, tobacco, and other drugs are discussed at home, at school and with friends***

When talking specifically about violence, it is important to ask about violence that might be happening at home, as well as in the community, since research has shown that many children are profoundly affected by community violence (Osofsky, 1994). Clinicians can also discuss the prevalence of violence on television and in the movies. Some specific questions that can be asked of patients and parents include:

- Do you ever see violence in your neighborhood or school or at home? (With younger children who may not be familiar with the word "violence," clinicians should be inquire specifically about guns, knives, other weapons, and people who fight and hurt each other.)
- How does it make you feel?
- What do you and people you know do when they get angry? Do you ever threaten, yell, push or hit? Do they?
- Have you ever been frightened by someone's behavior?

Working well with adolescents:

- ***respect***
- ***confidentiality***
- ***don't pressure patient to disclose***
- ***may use surveys to gather data about sensitive issues***
- ***ask about problems in family and in patient***
 - ***violence: at home, with friends, in community***
 - ***substance abuse: friends, family, patient's behavior***
 - ***relationships: dating, sex, violence, leave sexual preference open***

Adolescents: Respect is essential in working with adolescents. Teens want to be sure their health care provider is not judgmental, critical or disapproving. They need to feel assured that their providers genuinely care about them as individuals. A good way to convey this is to start the conversation with, "How are things going between you and your parents?"

Confidentiality, and its limits, are also important for teens. When issues such as suicidal ideation or suspected abuse or neglect are of concern, patients should know ahead of time what information might be shared with parents or another appropriate person.

Although adolescent patients frequently attend their appointments without their parents, they may still be reluctant to discuss difficult topics. In these situations, pressure to open up may be counterproductive. Instead, the clinician might say, "I want to respect your privacy and if there are certain things you do not want to talk about now, I understand. But I also want you to know that I am interested in helping you with any concerns you may have." Using a more sensitive approach may encourage a patient to open up, either during this initial discussion, or perhaps at a later appointment.

Because teens are often reluctant to discuss their problems, some studies have indicated that information can be solicited

by asking patients to complete at each regular visit a survey that covers a broad range of issues, including family problems, body image, depression, difficulties in school, health problems and sexual activity (Cavanaugh, 1986). Some teens, however, may be more reluctant to document their concerns on paper, given their concerns about confidentiality.

With adolescents, it is important not only to screen for family problems, but also to ascertain whether or not patients have become involved themselves in risky behaviors. Asking about peer involvement in such behaviors is a proxy indicator for a teen's own problems. Like younger children, teens can also be questioned about how problems such as violence and substance abuse are being discussed in school and with friends. Some questions to ask might include:

- Do any of your friends smoke? drink? use drugs?
What about you?
- When was the last time you drank alcohol or used other drugs? What did you try? What happened?
How often do you drink/use this substance?
- Have you ever worried that someone you know drinks too much or uses other drugs? Have you ever worried about someone in your family in this way?

If the patient denies personal involvement with alcohol or other drugs, providers can explore the reasons for non-use and affirm their decision. If patients have used alcohol or other drugs, they should be asked if they or anyone else has ever been concerned about this use, and if so, have they made any changes as a result.

Adolescents should also be asked about their romantic relationships. To minimize feelings of stigma and deviance, it is best to leave the issue of the partner's gender open initially. It is also important not to alienate patients who are not involved currently in romantic relationships:

- Tell me about your relationships. Are you interested in being close to boys or girls?
- Is there anyone in particular, boy or girl, you feel really close to?
- Do you date?
- Are you involved with anyone sexually? boys? girls? both?

- What do you do?
- Are you having any problems together? How are you dealing with them?
- Has anyone ever asked you to have sex with them?
- Has anyone ever touched you in places where you did not want to be touched? (This can be asked even if the patient says he or she is not involved with anyone sexually.)

It is also important for patients to be asked if their relationships include any kind of violence or abuse, and to assess whether or not the teen is at risk for becoming involved in abusive relationships in the future.

With most patients, the answers to these questions will necessitate little additional work on the clinician's part. Chart notations can be made as part of the family history and current health status. In some cases, however, clinicians may uncover a more significant problem. Often a single conversation and an appointment for a follow-up will be enough to address it. Other problems, however, will require more intervention.

when a problem is disclosed

When a problem is disclosed, there are three steps clinicians need to take:

- **Acknowledgment** - it is important not to ignore or minimize what has been expressed. These kinds of problems are sensitive because they are so stigma-laden, so any disclosure by a patient should be presumed to be the truth. Clinicians should tell patients they believe them and that they're glad the patient felt comfortable enough to say something. If the problem involves a parent or other caregiver adult, patients should be told that the adult's problem is not their fault, and should be encouraged to express their feelings about the situation. Clinicians should also acknowledge the severity of the problem, but make sure patients understand that the clinician and patient will explore possible solutions together.

In addition, clinicians can explain that the patient is not alone with this problem, that many other children and teens have the same problem. Patients need to know that they didn't cause a parent's problem, no matter what the parent might say. They need to know

that they can't cure or control their parent's problem and that parents need help to change their behavior, help that has to come from a professional, not a child or teen. Finally, patients need to understand that they deserve help for themselves and that help is available. If the parent is the source of the disclosure, similar kinds of information can be shared with them as well.

When a patient or parent has entrusted a clinician with personal information, he or she will be very anxious to observe the response. Clinicians can make sure they are responsive and empathic to both the verbal information and the affect of the patient. Some clinicians prefer to verbalize emotional responses as they are displayed, or comment when the affect doesn't seem to match the verbal information (for example, "You say you didn't care but you seem sad now"). Clinicians should refrain from making judgmental or punitive statements, no matter what their feelings on the topic at hand, and should take the time to assure patients that their feelings are understandable. They should also acknowledge how difficult it must have been to share this information - "Thank you for being honest with me. That must have been hard for you."

- **Additional information** - clinicians need to assess what other information is still needed. Often, there is not enough time to complete the interview, so patients (or parents) should be asked to return for a follow-up visit. It is important to remember that a disclosure is only a positive screen, not a confirmed diagnosis, and more information needs to be collected. The degree to which a clinician probes when learning of a problem should be determined by the practitioner's level of training in counseling and discussions about sensitive issues. When the clinician lacks adequate training, a referral should be made to a specialist for additional assessment. For example, "I am concerned that you may have an alcohol problem. In my opinion, we need to gather more information about this possibility. I would like you to see a specialist to help us determine if a problem exists, and to recommend possible next steps" (Werner, 1997).

Patients should not leave the visit without information to take home or a referral to appropriate resources. It is not the practitioner's responsibility to be familiar

When a problem is disclosed:

- **acknowledgment**
 - **share facts**
 - **express belief**
 - **dispel myths**
 - **use encouraging and supportive body language**
- **additional information**
 - **schedule follow-up visit**
 - **disclosure is a positive screen, not a diagnosis**
 - **make referral to specialist if clinician does not have adequate training to pursue issue**
 - **provide patient with take home materials on issue**
- **assess immediate danger**
 - **report abuse or neglect**
 - **don't avoid reporting responsibility**
 - **inform patient and family that report is being made because of legal requirements**
 - **review safety plans**
 - **make referral**

with every problem introduced; the important thing is to know where to find useful information and quality referral resources and how to access them.

- **Immediate danger** - providers must assess whether or not their patient is in immediate danger as a result of the problem disclosed. For example, *if abuse or neglect is reported or suspected, health care providers are legally mandated to report it to the proper authorities*. While the prospect of making a report can be daunting, this is part of the clinician's job, and the problem is not a secret to either the patient or the family.

All clinicians need to be familiar with the laws for reporting in their state. Every state has a child abuse and neglect hotline; if the protocol is unclear, 911 or an emergency hotline should be contacted. The patient/parent needs to be informed when a clinician makes a report, and should understand that the report is being made because the practitioner is mandated to do so by law, and because there is concern about the patient's safety. Reports should not be kept secret from patients and their families.

When to break confidentiality:

- **if problem disclosed is life-threatening to the patient or someone else**
 - **patient should be told that parent will need to be informed**
 - **patient should be asked about the best way to inform parent**
- **if problem is risky, but not life-threatening**
 - **ask patient what parent might suspect**
 - **ask permission to inform parents**
 - **respect patient's decision whether to inform parents**

If the patient discloses a personal problem such as drug use, risky sexual behavior or involvement with violence, the clinician has to make some decisions. If the behavior involves a threat to the safety of the patient or another individual, the clinician should break confidentiality, always explaining to the patient beforehand that because someone's safety is threatened, the parent needs to be informed: "This is a very serious issue. How can I help you talk with your parents about this? Do you want me to tell your parents or would you prefer to tell them first, or would you prefer that we talk to them together?" When the behavior is not life-threatening, but risky, the clinician might ask the patient if it would be acceptable to inform the parent. For example, a 15-year old who discloses drug use or heavy alcohol use might be asked:

- Do you think your parents are suspicious about your alcohol/drug use?
- What do you think they already know? What do they suspect?
- What do you think they would say or do if they found out?

- Do you think you could go without alcohol/ other drugs for a few weeks (abstinence challenge)

Ultimately, however, it is the decision of the patient whether or not to involve the parents in these situations. If the patient prefers not to inform the parent, then the clinician should discuss ways to reduce the risks or stop the problem behavior, and follow-up in a timely way.

In non-emergency situations, it is probably that the patient has lived with this problem for quite a while. Most children are very adept at coping with troubles at home. The practitioner's job is not to solve a chronic problem in 15 minutes. Their job is to help the child ultimately achieve a safe resolution. Therefore, clinicians should:

- be sympathetic
- develop a treatment plan
- refer the child or adolescent to appropriate resources
- advocate on their behalf in appropriate contexts

talking with parents

In most cases, when a patient discloses a family problem, the parent will need to become involved. When talking to parents about the problem, clinicians need to clearly express their concern for the well-being of the child, and simultaneously their support for the parents, no matter what their feelings about the behavior of concern. The clinician should articulate a willingness to help both the parent and the child, and recognize that getting help might be very difficult for the family. Notations in the chart should be made to prompt follow-up at future visits. Statements such as “I am concerned that your husband’s use of alcohol may be affecting your son’s health” and “Dealing with family violence can be difficult. I want to be helpful to the whole family” convey genuine concern and openness to next steps.

It is very important for clinicians to attempt to keep their own attitudes about the problem in check. Excessive enthusiasm for a particular issue or treatment option, criticism or judgment of a family, or discomfort with a topic can be easily conveyed with either words or body language, and should be kept to a minimum.

Talking with parents when a problem has been disclosed:

- ***express concern for patient and support for parent***
- ***keep emotions in check***
- ***reserve judgment until all facts are known***
- ***make referrals as appropriate***
- ***inform parents of any next steps to be taken***
- ***discuss concerns based on clinical observations rather than on patient's statements***

Serious problems such as sexual abuse or physical violence may cause providers to feel very distressed. However, regardless of the clinician's feelings about the disclosure, conclusions should be reserved until all the facts are known. Clinicians should try to remain objective and explain their concerns to parents based on clinical observations rather than on the child's statements, to ensure accuracy and avoid any potential repercussions. Practitioners should also share with the parent, if appropriate, their legal obligation to report abuse and neglect.

If the clinician is concerned about a child's response to domestic violence, caution should be exercised. The safety of both the abused partner as well as the children may need to be protected. There are many reasons women (as the more likely partner to be abused) do not leave their spouses or partners. Confidentiality can make a life or death difference in this situation, especially in rural areas where resources are more limited and people are more likely to know each other (Iowa Supreme Court Task Force, 1994).

Clinicians should inform parents of any further action that will be taken. Practitioners may want to involve another provider to administer additional exams or interviews. Referrals may need to be made for mental health treatment if:

- the presenting symptoms have persisted for longer than usual
- the problem is chronic
- the trauma was particularly violent or involved the loss of a caretaker
- the caretaker is not empathic to the needs of the child or adolescent
- the environment is not safe

getting the most out of referrals

In order to help family members obtain treatment, the clinician must recognize that the family has three tasks to master first: acknowledging the problem, recognizing the ways they are being affected and each individual's need for assistance, and understanding that the other family members did not cause the problem and that many other families have experienced these same problems.

While most health care providers are extremely adept at

making referrals to specialists for physical problems, few have extensive experience with referrals that offer assistance with psychosocial concerns. Below are a few tips to help maximize the effectiveness of referrals. While it might not be possible for the busy clinician to take all these steps him or herself, it can be helpful to enlist the support of others from the office. Clinicians and their office colleagues can:

- try to be familiar with the resources on their referral list. If a book, article, pamphlet or other publication is being recommended, it should be reviewed first to make sure it is appropriate and would help the patient.
- let patients and their families know as much as possible about what to expect in a program, counseling situation or support group ahead of time. While getting help can be a relief, the first steps are often overwhelming. In some cases, help can seem so scary that a simple challenge, like having to transfer buses to get to a program, can seem insurmountable and contact is never made. Letting patients and families know what to expect in advance can ease the tension and make it more likely that they will follow through with referrals.
- try to have names of contact people at a support group or counseling program. When an on-site contact person knows that a referral has been made, the patient is usually treated well. Many 12-step group meetings can be attended by the public, and mental health professionals are open to working with the medical community.
- encourage the patient or parent to call the program while he or she is still in the office. For many people, getting help feels so daunting that making that first phone call is something to be avoided or delayed.
- share with the patient or family how they might feel: nervous and anxious, or even eager and calmer.
- try to stay neutral and non-judgmental when making a referral. Enthusiasm for a particular program or disapproval of behavior may be overwhelming and discouraging. Be open to negotiating options that are agreeable to the patient and family.
- follow up with patients to see how the referral worked out. This supports the referral process and makes clear that the clinician is not abandoning the patient, which is often the underlying fear when a referral is made.

Maximizing the use of referrals:

- ***be familiar with the resources on the referral list***
- ***tell patient what to expect***
- ***have names of contact people at programs and treatment centers***
- ***encourage patient to call for information or appointment before departing***
- ***share range of possible emotions***
- ***be neutral and non-judgmental***
- ***follow up with patient and/or family***
- ***reassure patient and parents that they are not being abandoned***

There are programs in virtually every community designed to assist families in need. A look through a local phone directory or a call to a nearby family counseling center can be good starting points for developing a referral list. Some resources that might be included on the list are:

- child abuse prevention and treatment programs
- school guidance departments and student assistance programs
- psychotherapists with expertise in such issues as family violence or substance abuse
- local councils on alcoholism and drug dependence
- self-help groups that meet locally
- family service agencies
- nearby substance abuse treatment centers
- municipal hotlines for family violence or substance abuse
- social work departments of local hospitals
- mental health centers
- libraries or bookstores

Clinicians may also want to share with patients a list of books, pamphlets and other publications. The list in the back of this manual is intended to serve as a starting point.

When referred to other sources, patients and their families may need clarification about the clinician's long term role and the purpose of the referral. Providers should emphasize their ongoing commitment to the patient and continued relationship.

Working with a Diverse Population

Sensitive topics can be even more difficult to discuss if there are cultural and/or gender differences between the clinician and the patient or family. Cultures vary in their attitudes about what constitutes appropriate interaction and discussion. Some of these differences have been documented. However, there is significant variation within groups, and each patient and family requires an individual assessment of beliefs and attitudes.

The race and ethnicity of patients can influence the questions clinicians ask and the measures they prescribe. Research suggests that white clinicians are much less likely

to ask lifestyle questions of non-white patients. They are also less likely to prescribe preventive measures to these patients (Levy, 1985). Clinicians need to be aware that these possibilities exist and make sure they are not unwittingly falling into an alienating or unhelpful behavior pattern.

Language may also be an issue for some patients. If a patient is not comfortable communicating in English, clinicians might try writing out instructions and treatment plans to make it easier for patients to follow. In this situation, it becomes especially important that patients repeat back any instructions in their own words. Other options include:

- pamphlets and other patient literature in different languages - local departments of health or nearby social service agencies serving a particular population might be possible resources for information
- translators - translators should to be used with caution. They may translate information in such a way that leaves out important details, or even purposefully censor key facts. In addition, patients and their families might feel uncomfortable talking about sensitive topics through a translator, who may be part of their same community (Holden and Serrano, 1989).

Socio-economic status can also affect treatment plans. Uninsured and poor patients may not be able to afford a second visit or transportation to a referral. In many clinic settings, there may not be a primary care provider assigned to each patient. In these cases, it is important for the interview to be carefully documented. Referrals should be made during the first visit so patients know their options even if they see a new provider. It is also helpful to have on hand a list of clinics that accept Medicaid, have sliding fee scales for patients without private insurance, or provide transportation reimbursements or alternatives for patients in need.

Dealing with Sensitive Issues Over Time

Clinicians who are fortunate enough to work with their patients over a long period of time can put protocols in place that foster an open, trusting relationship and facilitate the discussion of sensitive topics. A parent who is told during the first visit that it is the clinician's normal practice to speak with the child alone for at least a few minutes during every office visit will not feel threatened or surprised when he or she is asked to leave the room.

Diversity issues:

- ***recognize potential for unconscious bias***
- ***be aware of potential language difficulties***
 - ***have patient education materials in other languages***
 - ***use translators, even professionals, with caution***
- ***understand implications of family income and ability to use referrals, resources or even keep appointments for follow-up***

PANDORA'S BOX

Dealing with sensitive issues over time:

- **ask questions about stress and psychosocial questions routinely**
- **sustained attention to psychosocial problems:**
 - **helps identify relapses in behavior**
 - **allows clinician to discuss risk and resiliency with patients**

Practicing interview techniques:

- **attend trainings**
- **record (audio or video) clinical visits to assess personal style and identify areas for development**
- **practice with a trusted colleague**

Clinicians who identify a problem should not consider it a one-time crisis. The concern should be noted in the patient's chart, and flagged, so that the provider can revisit the issue during future visits. For example, a provider who is able to identify a father's substance abuse in the case of a 3-year old boy should continue to ask about the status of the substance abuse, and if it has caused any other problems, such as family violence. Sustained attention to these issues may help identify any relapses in a parent's behavior, and may also help clinicians discuss risks and resiliency with patients as they age. However, clinicians need to be sensitive to the parent's preferences regarding discussion of "adult issues" in front of a child, and respond appropriately.

Practicing these Techniques

Learning to address sensitive topics in a typical pediatric interview takes time. It may be difficult to incorporate these techniques at first. The words may sound hollow and require practice. While it is best to receive professional training on these kinds of communication techniques, clinicians unable to access professional development trainings can try to establish their own "home grown" trainings, either by bringing together a group of interested practitioners to meet with a mental health professional skilled in these areas, use video/audiotape to record patient visits for later critique, or even to work informally together on these issues. These techniques will ultimately give providers a framework with which to address a host of topics in an efficient and humane manner.

Summary

Ultimately, the goal of the provider is to help the child achieve a safe resolution to their problems. It is not the role of the health care provider to solve all psychosocial problems in one visit. Unless the situation mandates reporting, it is good to start with a sympathetic ear, listening and learning about the problem, and then to develop a treatment plan with the child and/or parent, refer to the appropriate resources and advocate for the child in appropriate contexts.

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