PRACTICAL SKILLS

How to communicate with children and young people in distress

Strategies for supporting children and young people to share information about their wellbeing and safety

LEARNING POINTS

- One in 10 young people aged between 5 and 16 years experiences mental health difficulties
- Mental health of children and young people is affected by multiple protective and risk factors
- Give children and young people the opportunity to choose where they discuss how they are feeling and who should be present, and make clear to them the concept of confidentiality
- Do not assume that all young people who experience distress have a mental health condition—be careful not to pathologise normal emotions and reactions
- Be flexible and responsive in your consultation style. Tailor your approach to the degree of distress and the circumstances of the assessment
- A psychiatric assessment entails multiple meetings, using information from different sources

One in 10 young people aged between 5 and 16 years experiences mental health difficulties.[1] Children and young people often communicate their distress differently from adults, in more subtle and unpredictable ways.

A key skill f or any clinician is finding ways to communicate with patients in a flexible, responsive manner, and this is particularly put to the test when building a rapport with children and young people. Most children and young people experiencing distress will not have a mental health condition, and it is therefore important to try not to pathologise normal emotions and reactions.

This article introduces the biological, psychological, and social factors to consider when exploring children and young people's mental health and suggests strategies you can use to support them to share information that is relevant to their wellbeing and safety.

Though psychiatric diagnoses are not described in this article, we hope the following pointers will help you to gather pertinent symptomatology, which you can discuss with a senior member of the team.

Case study

You are a foundation year 2 doctor on rotation at a busy general practice. Emily, 15, is brought to her appointment by her mother, who has been concerned about her for two weeks. Emily has been refusing to attend school. She has been spending most of her time in her bedroom, online, not joining family meals and is seeing her friends less. She seems to have lost weight. This morning her mother noticed some cut marks on her forearm, and Emily told her she had used a razor blade to hurt herself. Emily is not known to mental health services. You have been asked to see her before the general practitioner joins you. You are the first person to talk with her about her current difficulties. Emily has poor eye contact, is tearful, and doesn't want to talk to you with her mother in the room. Her father is also in the waiting room, and you saw Emily's parents arguing in front of reception staff earlier; now they are not speaking to each other.

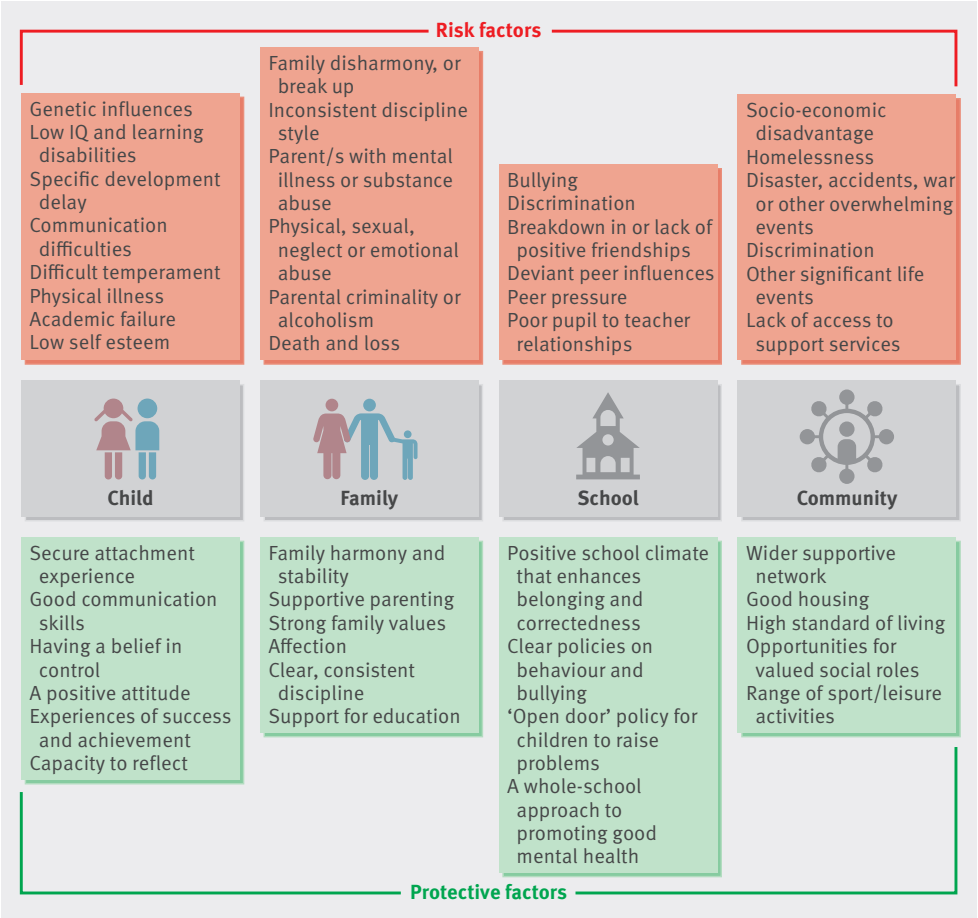

Fig 1 Risk and protective factors for children and young people's mental health, Public Health England[19]

Before beginning the consultation

1. Choose the right time and environment

Regardless of where a child or young person presents—the emergency department, general practice, school—consider the immediate safety of the child, their family, and any interviewees before you begin. Young people should be given the opportunity to choose where they discuss how they are feeling—for example, classroom, office, or side room—and with whom—for example, they might want to talk to a male or female doctor. If they are unwilling to talk on a particular occasion, offer another time or place.[2]

2. Decide with the child or young person who should be involved

A child or young person might prefer to be seen alone or might agree to talk only if they are accompanied by their parents, carers, or a friend. When disclosures concerning risk are most likely—risky thoughts and behaviours—you should aim to see the child or young person and their parents or carers separately.[3]

3. Make clear the concept of confidentiality

A child or young person who is Gillick competent (capable, although under 16, of understanding the nature of the treatment and of consenting to it without parental knowledge or permission)[2] and is not at immediate risk can opt for what they tell you to remain confidential.

Interviews with older children or young people should begin with a statement around medicolegal boundaries—for example, "I will respect your right to keep things you say between us, but if I thought you, or someone else, was at risk I might have to tell your parents or other people, like a social worker. If this was needed, I would tell you beforehand and involve you."

Beginning the consultation

Introduce yourself by giving your first name and surname. Ask the child or young person what they would like to be called. If they are sitting down, ask if it is all right to sit down with them. Consider starting the conversation by acknowledging their distress: "I'm sorry to see that you are upset/not feeling well."

Your style and delivery, including language used, must be tailored to the child or young person's developmental, rather than chronological, age— they may, for example, have learning difficulties. Do not try to be cool: children and young people quickly pick up on adults who try too hard.

Start looking for evidence that the child or young person might be physically unwell (in pain/nauseated/confused)—multiple medical problems (infections, electrolyte imbalances, physical injuries) could present as emotional disturbance, especially in younger patients. If you suspect an underlying physical or organic cause, make sure appropriate investigations or assessments are arranged.

Show what you already know ("I've heard you are in year 10 at Christchurch School "), and what you don't ("My questions will help me understand how I can help today").

An opening question, such as, "How have you been feeling recently?" should be followed up with questions that expand on this context, such as, "Is there anything that has been worrying or upsetting you? Is that worse in a certain place or time, or is it always the same?"

Don't assume you have understood what the child or young person is thinking. Regularly check with them to see you have understood them correctly. For example, instead of, "I know it's the exam period, you must be under lots of stress," try, "Have I understood correctly that it's school exams that are worrying you most?"

Don't avoid asking difficult questions: be direct and unequivocal when covering more

serious matters such as potential abuse. For example, "Has there ever been a time when someone has done something which has upset you, like touching you when you haven't wanted to be touched, or hurting you?"

When assessing suicide risk, there is a widespread fear among healthcare professionals of making things worse.

Asking, "Did/do you want to die?" is not going to generate suicidal thoughts. Rather, it might bring some relief to the child or young person and show them they have someone who will listen to them.

Take into account cultural factors. Children and young people have families or social networks with very different values and expectations. Don't assume that the pressures that they face are all the same.

Although you should be careful not to pathologise normal emotions and reactions in children and young people experiencing distress, consider screening for developmental disorders such as autistic spectrum disorder and attention-deficit/ hyperactivity disorder in your assessment.

Tips for communicating effectively with children and young people

- Ask them to list the principal problems on their mind, in descending order of importance. This can guide you in where to aim your history taking.
- Ask them to rate aspects of their mental state. For example, on a scale of 1to 10, how would you describe your mood? If 10 is "best," find out their current score compared with their baseline.
- Ask them the "Aladdin" question: "What three things do you wish you could change, rather than have?" Their answer may help show what a child or young person might want. For example, "I wish that I wasn't bullied at school" should reveal what key things they desire.
- Avoid asking "why?" questions. Children and young people might lack the analytical skills to answer, and you may be met with shrugs or "I don't know." "What makes you angry?" is much better than, "Why are you angry?"
- Don't take initial answers at face value. Often "I don't care" really indicates, "Help me figure out how to express how I'm feeling."
- Children and young people tend not to initiate conversation with adults spontaneously. They have less emotional awareness and vocabulary than adults; therefore aim to use concrete rather than abstract thought.
- Some children and young people, especially younger children, may respond well if you first engage with them via play or drawing.

After the consultation—what to do next

Discuss your conversation with the child or young person with a senior colleague. Children and young people should be partners in their own care, so it is important to share your impression with them—and their parents, if appropriate—and agree a plan of action.

It is essential at the end of the interview to make arrangements for a follow-up appointment as well as providing advice regarding what to do in case of crisis. This advice and the relevant contact numbers should be given as a written document so that they can be easily accessed.

Healthcare professionals can be affected by distressing stories. Seek support from peers or colleagues if you find a consultation upsetting.

Case study: areas to explore with Emily—common sources of distress in children and young people and their evidence base

Home situation

Emily's parents have been arguing: what is her home situation? What might have destabilised her family system? Parental conflict has been associated with an increased risk of self harm,[3 4] as have parental mental disorder and deaths in the family.[5]

Performance at school

Emily has poor school attendance: what academic pressures exist for her? Achieving high levels of attainment in exams can be all-consuming, particularly if a child or young person has a perfectionist attitude.[6]

Social isolation

Emily has been socially isolating herself: does Emily have friendship difficulties? Children or young people who feel lonely or are socially isolated are more likely to be distressed and self harm.[7] Bullying in all its forms has been linked to distress, self harm, and violent behaviour.[8]

Body image

Emily is losing weight: what is her perception of herself? Low self esteem has been associated with increased risk of self harm.[9] Consider if she sees her body in an unusual way (for example, "I'm too fat/thin") or if she has an eating disorder. Among boys and men, muscle image can be a source of dysmorphia and distress.[10]

Sexuality

Is Emily concerned with her sexuality or sex or both? Being lesbian, gay, bisexual, or transgender has been associated with an increased risk of attempted suicide at an earlier age.[11]

Time spent online

Emily is spending a lot of time online: is her mental health at risk via the internet? Children and young people are more susceptible to peer and social network pressures than adults.[12] Social media are of increasing importance to this age group, and though most children and young people think that social media have a positive role in their lives, they also carry new risks.[13]

- Cyberbullying and internet harassment have been linked to an increased incidence of suicidal ideation in adolescents.[14]
- Sexting has been linked to adolescent distress, particularly in girls, who can face more pressure and greater judgment as a consequence of sharing images online.[15]
- Compulsive internet use is a predictor for poor mental health among adolescents,[16] whereas high use has been shown to affect propensity to depression for both sexes and sleep in girls.[17]
- Online risks may also include gambling or exposure to websites and blogs about self harm, suicide, and eating disorders.[13]

Abuse

What else has Emily faced that might make her more prone to expressing her distress in the way she has? All forms of abuse—though particularly sexual abuse—and early onset of sexual activity are associated with a propensity to self harm.

Substance misuse for an adolescent

Is substance misuse a problem? Frequent alcohol consumption is correlated with predisposition to self harm. Drug use is less well correlated but relevant.[18]

Children and young people have families or social networks with very different values and expectations. Don't assume that the pressures they face are all the same

Rory Conn, year 6 specialist trainee in psychiatry, Whittington Hospital NHS Trust, London, UK
Adam Monsell, year 2 specialist trainee in psychiatry, Whittington Hospital NHS Trust, London, UK
Helen Bruce, consultant psychiatrist, East London NHS Foundation Trust, London, UK
rconn@doctors.org.uk

Cite this as: *Student BMJ* 2017;25:j1696