

## Assessing Pediatric Mental Health in the Family Medicine Setting, With a Focus on Irritability - A Qualitative Study

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### ABSTRACT

Primary care practitioners are often called upon to differentiate normal from abnormal irritability, but little education is provided to prepare them to do so. Assessing the mental health of a child is a challenging task. This study used appreciative inquiry to answer the question, "How do family medicine practitioners assess and treat irritability in school aged children?" To gain an initial perspective on how practitioners in Family Medicine (FM), Pediatrics (PED), and Psychiatry (PSY) evaluate and treat school-aged children, 17 volunteers participated in in-depth interviews. The participants in primary care expressed frustration over the lack of time and specialized knowledge they had to accurately assess children, even though they were often the first clinician consulted when problems arose. There were clear and sometimes contradictory differences between how practitioners with a general vs. specialized practice assessed mental health status in the clinic setting. In addition, input on treatment approaches revealed that medication prescription was more common in primary care and therapy preferred by the PSY participants. School referrals were common pathways to the FM and PED clinic, where practitioners often focused on assessing functional status to assess normal vs. abnormal irritability. Based on the initial assessment, FM and PED participants often referred the child to more specialized treatment, particularly when complex medication prescription was involved. They were also significantly less confident of their ability to evaluate mental health status, while child and adolescent psychiatry participants were supportive of having more initial triage and possible treatment occur at the primary care level.

### INTRODUCTION

Pediatric patients visit primary healthcare providers in ambulatory settings an average 31 times from birth to age 21 for general wellness visits[1]. Additionally, in 2012 alone, 5.9 million United States children were hospitalized[2], adding to the average number of medical interactions. Annually, millions of children further encounter ancillary medical caregivers, including medical assistants, nursing staff, laboratory and radiology technologists, occupational, speech, and physical and mental health therapists. These children can also be passive participants in sometimes-stressful conversations with administrative professionals regarding finances and insurance coverage. Most concerning, up to 20% of the population reports feeling "white coat syndrome" when coming into contact with medical doctors.

Children commonly report feeling afraid or anxious as they anticipate and engage in healthcare settings with medical professionals[4-6]. Due to their developmental level and limited cognitive development, children use behavior, instead of words, to communicate the emotions they feel. Common behavioral

demonstrations of fear, anxiety, and helplessness include aggression, withdrawal, lack of cooperation, and regression. Of note, psychological and behavioral distress has been present regardless of the incidence of invasive or painful healthcare. This distress impedes provider execution of medical protocols, thus requiring more time in the treatment process.

Be that as it may, enlargement of icily combined ESs (e.g., methylene blue, unbiased red, decolorized metabolites of material colors) to hoist pace of contamination corruption would be clearly not ecologically fitting because of undesired presentation of optional contaminant(s) for treatment. On the off chance that ES supplementation to improve activity proficiency of MFC is inescapable, enlargement of normally present ESs would be toppriority determination to limit natural effect on lives. As to structures of ESs, when electron-pulling back gatherings (e.g., hydroxyl (-OH) substituent(s)) were available on benzene ring ortho or para to one another, such synthetic species would emphatically display electrochemically stable electron-carrying attributes to animate force age in MFCs. That is, within the sight of hydroquinone-like substance structures, such synthetic compounds could possess promising electron-transporting attributes of ESs to invigorate ET productivity in MFCs. In this manner, utilizing polyphenolics (i.e., -OH substituents)- rich therapeutic spices and consumable greenery (e.g., Camellia and non-Camellia tea) as ESs appeared to be all the more electrochemically suitable to remove bioenergy from organics oxidation in MFCs.

Likewise, restorative spices – *Lonicera japonica* (Jīnyín-huā) and *Syzygium aromaticum* (Dīng-xiāng) contained noteworthy measures of polyphenolics and flavonoids antioxidants. In this way, cancer prevention agent and ES abilities of polyphenolics-plentiful common bioresources may be considered as inducible electrochemical qualities that could be controlled by exogenous conditions for bioelectricity incitement. That is, if ES exercises could be communicated appropriately, the nearness of polyphenolics species may likewise synergistically cooperate with electrochemical exercises for ET incitement in MFCs. In actuality, significant constituents of Camellia tea-catechins could assume double jobs of either cancer prevention agents or ESs at suitable conditions. In spite of the fact that Chen and Hsueh recommended conceivable motivations to clarify polyphenols-rich eatable verdure as ESs (e.g., flavonoids cancer prevention agents as conceivable ESs) for bioenergy applications (e.g., MFCs, electrofermentation), correlation upon various common bioresources to propose promising competitors had still remained essentially open for conversation. Obviously, this would prompt unusual practicability of utilizing suitable ES sources to boost bioenergy extraction. Here, relative evaluation upon test tests showed that concentrates of Camellia tea (e.g., green tea, oolong tea, Pu'er

tea and dark tea) would be the most proper to animate electron transport marvels in MFCs. Follow-up studies would decode whether just some critical synthetic species as principle effectors or synergistic collaborations of a few electrochemically dynamic animal varieties legitimately expand power age in MFCs.

### **ANXIETY AND TRAUMA IN THE HEALTHCARE SETTING**

Throughout a child's life, approximately 15% to 20% will encounter some form of relatively severe trauma. Developmentally speaking, even common events, including medical care can lead to heightened anxiety, and trigger trauma responses in children. Because children are bewildered in an unknown medical environment, as caregivers are taking over control of their bodies, they feel a loss of autonomy and control. Further, unmet needs, sense of danger, and lack of competence amplify anxiety. Children fear mutilation, and suffer from guilt, pain, rage, and similar manifestations specific to their developmental level. Anxiety-provoking experiences such as hospitalizations and medical care can effect a child's physical growth, personality, or emotional development. In some cases anxiety-based trauma may prejudice the development of behavioral, emotional, or cognitive disorders.

### **FACES OF HEALTHCARE-INDUCED TRAUMA**

Most people can relate to an experience in their lives during which a healthcare visit or medical procedure was upsetting and anxiety-provoking. Some may even describe their experience as traumatizing. Distressing scenarios might include vaccinations as a child, a medical diagnosis with a poor prognosis, or perhaps a diagnosis requiring surgery. This author recalls an early childhood experience of undergoing anesthesia for a peritonsillar abscess. Her fear of and fight against needles prohibited a pre-op IV start and a mask was placed over her nose and mouth. She gasped for air, all the while pleading to the anesthesiologist she could not breathe. Her fear was dismissed and minimized when the anesthesiologist responded by telling her "she was fine". This author remembers feeling like she was in danger because she felt as if she could not breathe. She had no pre-surgical preparation for the sudden fear and panic. Had she been told in advance what it might feel like to have a mask placed over her face, or to know it is a common feeling to gasp for air as part of the anesthesia process, her fears and therefore healthcare-induced trauma, would have been prevented. Sadly, this is not an uncommon experience for children in healthcare settings.

Another example is Amelia, an 18-mo old, female recovering from acute stress disorder due to healthcare-induced trauma resulting from repeated episodes of care in the Emergency Department (ED) at a highly regarded Children's Hospital for flu-like symptoms causing severe dehydration leading to

listlessness. Each time she was taken to the ED by her high-functioning parents, they were instructed to hold her down for catheterization in order to obtain a urine sample to rule out bacterial infection. Additionally, she was held down for intravenous (IV) fluids tube insertion, which was difficult to insert and took several attempts to place. This process of catheterization and IV attempts repeated itself several times as she was evaluated by the physician in the ED, released, evaluated again in the ED, admitted into the hospital, discharged, and then re-admitted. This little girl was scared, confused, and seemingly terrorized by strangers (medical providers) and those she trusted (parents). Each of these ED admissions took hours to complete as the child lay helpless in defense to the medical professionals that needed to triage and treat her illness. The parents looked on with bewilderment, doing their best to keep calm despite their daughter's condition.

### **CONCLUSION**

Pediatric patients require an extra level of care in their healthcare process. They require added patience, flexibility, and containment for their ever-changing emotions. Their primary need is to know they are safe and to be given age-appropriate and developmentally-appropriate information in order to combat heightened anxiety levels and trauma responses, which can hinder the delivery of quality healthcare and create harmful long-term psychological effects. Healthcare providers have a valuable opportunity to control the negative outcome of pediatric stress in the medical setting, no matter their function in a child's episode of care. By utilizing the four principles in the CARE protocol: (1) Choices: Provide power in a powerless environment; (2) Agenda: Letting the patient and family know what to expect and what is expected of them; (3) Resilience: Start with strengths and reframe negatives; and (4) Emotions: Recognize and normalize common fears and responses providing emotional support, children will feel emotionally safe and protected in their medical treatment.

Understanding the risk of anxiety and trauma in pediatric patients with regard to receiving medical care is imperative to effective outcomes. Although universal application can be made to patients throughout the lifespan, the mission of CARE is to provide a voice to the world's most vulnerable, powerless, and disregarded population in medical care-children. The CARE protocol was developed to foster trust in medical care providers and to mitigate the risk of anxiety and trauma in pediatric patients while receiving necessary and pertinent medical care. Most patients remember how they feel about an episode of care, not what was said or done. CARE enough to allow pediatric patients to feel empowered and safe in their healthcare experience.