Guarding the Mental Health of Children:

The Role of the Primary Care Physician

BY SHELDON LEVY AND TATIANA BALACHOVA

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The word "childhood" often conjures up images of carefree days spent playing and worrying about little, but, for many young people, childhood is a troubling time filled with anxiety or abuse that often manifests as mental or behavioral health disorders. The majority of children who suffer from psychosocial problems do not receive any specialized mental health services, although they often see a physician for general medical problems.[1,2] As such, primary care physicians can play an important role in the prevention and treatment of such disorders. Their awareness of, and attention to, some of the causes of mental health problems are important first steps in implementing interventions that can be done within the context of a primary care visit. Additional consultation with mental health professionals can assure that a child and his family receive adequate treatment and learn to interact in ways that mitigate the development of more severe problems.

While many behavioral and mental health problems can be treated with medication, the ideal primary care approach is to begin with behavioral intervention. It is therefore important to screen children and young adults for mental and behavioral health problems during regular visits to a clinic. Questions posed to parents such as "Is there anything worrying you about your child's behavior right now?" or "Are you worried about any changes in your child's behavior since I last saw you?" may help a doctor detect problems that have not physically manifested.

This article reviews the most common mental health problems experienced by children and provides appropriate primary care interventions, focusing mainly on behavioral approaches. Pharmacological interventions may be useful, but are best done in consultation with a child psychiatrist. Awareness of these disorders and their appropriate management has the potential to keep many children from developing more severe symptoms and/or lifelong difficulties.

Anxiety Disorders

Many children experience moments of anxiety, panic, and/or fear. When these episodes become overwhelming and chronic, they can interfere with everyday functioning and may take on the definition of a disorder. The most common anxieties experienced by children and recognized at the primary care level are separation anxiety, generalized anxiety, social phobia, panic disorder, and post-traumatic stress disorder. Each is discussed more fully below.

Separation Anxiety Disorder

When a child becomes extraordinarily frightened about leaving home to go to school or about being separated from a caregiver, the child may have a problem with separation anxiety. It is only considered a disorder, however, when the anxiety is developmentally inappropriate and excessive. For example, a 5-year-old is exhibiting excessive and inappropriate anxiety if he is frightened that something terrible might happen to a parent at home if he leaves to go to school. His behavior, however, may not be inappropriate if the child is living in an environment that includes domestic violence, civil conflict, or war.

When screening for separation anxiety, the primary care physician should begin by asking the parent(s) about changes in the home or recent traumatic events—such as accidents or injuries to the child or a family member—to determine if a particular situation has made it difficult for the child to leave his parent(s). If such a situation is present, reassuring the child about his fear to make him feel more secure is the next step. A particularly helpful technique is to have the parent(s) talk with the child about his worst fears, by asking, for example, "What are you afraid will happen if you go to school?" Talking about these fears often alleviates the problem. If, for example, the child responds that he is afraid the house will be empty when he returns from school, the parent can reassure him that this will not happen and make sure to be home when the child returns so that he understands the parting is not permanent. If this does not cause the separation anxiety to pass, further mental health consultation may be helpful.

Generalized Anxiety Disorder

Excessive anxiety and worry about various aspects of life such as school, family, friends, and activities are the signs of a generalized anxiety disorder. It may include somatic complaints such as fatigue, muscle tension, headaches, irritability, and/or poor concentration. In such a case, physicians should work first with the parent(s) to understand the history of the anxiety and to explore possible social and familial causes, such as problems at school, difficulty with peers, domestic violence, parental substance abuse, neglect, or divorce.

Physicians who suspect that a child has been abused or neglected should talk to the child without the parent(s) in the room and should take appropriate action (see section on child maltreatment). If parental discord or substance abuse is identified, the physician should first try to help the parent(s) find ways to address these problems through substance abuse treatment programs, Alcoholics Anonymous, or another appropriate venue. In addition, the physician should raise the parents' awareness about the possible relationship between these problems and their child's emotional and behavioral health.

If the source of a child's anxiety is not obvious, the physician should encourage parents to talk with their children as discussed above and to try to reassure the child about their problems and fears. If this does not cause the anxiety to pass, further mental health consultation may be helpful.[3]

Social Phobia

Children who experience social phobia—also known as social anxiety disorder—have a persistent fear of social or performance situations, such as going to parties, reading aloud, or making presentation in class.[4] The definition of this anxiety states that the child must demonstrate the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults. One intervention the primary care physician can suggest to help the child become less phobic is to have him interact in progressively larger group situations and receive positive feedback from peers and adults who are watching.

Panic Disorders

Panic disorders are more often seen in adolescents than in children, and usually manifest in the form of a panic attack. This attack may include several physiological symptoms, such as palpitations, sweating, chest or abdominal pain, and shortness of breath. After the first attack, the child may develop anticipatory anxiety that evolves into avoidance of places where the attack could occur.

The primary care approach to managing this disorder is to explain to the child how the symptoms may occur—for example, thoughts about taking a test may lead to hyperventilation—and how to apply some behavioral management techniques to control the symptoms. These techniques include explaining to the child what changes in body sensations and feelings occur when hyperventilation begins, teaching him how to relax when he feels these changes occurring, teaching him "thought blocking"—to think of something else besides the test, thereby blocking the thought causing the anxiety—and reassuring him that the feeling will eventually pass.

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Post-traumatic Stress Disorder

Post-traumatic stress disorder occurs in children who have been exposed to an overwhelmingly traumatic event, such as physical or sexual abuse, warfare, or a natural or man-made disaster. Symptoms in children include disorganized or agitated behavior, recurrent and intrusive recollections, avoidance of stimuli associated with the event, and numbing of general responsiveness—an inability to recall important aspects of the trauma or diminished interest or participation in significant activities, for example. Recurrent and intrusive recollections may manifest themselves through repetitive play involving the reenactment of themes associated with the traumatic event. Insomnia and irritability may also be present.

When a physician becomes aware of these symptoms, a detailed history of the child's behavior should be obtained, as should knowledge about recent traumatic events, including the death of a family member. The physician should also ask the child about recent events that frightened him, as well as about what makes him happy, sad, or scared, and what he does when sad or frightening feelings arise. If the physician notices any suspicious physical injuries or a child seems particularly guarded during a physical exam or when answering questions, the doctor should ask the parent(s) to leave the exam room so that a private conversation can be held with the child. (For suggestions on how to do this, see "Setting the Stage for Effective

Communication with the Adolescent Patient," page 25, *CommonHealth*, Spring 2001.) At this point, the physician should inquire about possible physical or sexual abuse or neglect. Physicians who suspect abuse should take action as described in the maltreatment section below.

When the cause of the trauma is not physical abuse, the first approach to treating the symptoms is to allow the child to come to terms with the experienced trauma through repetitive play exercises. Using this technique, the parent talks with the child about what is going on while they are playing, paying particular attention to aggressive actions. When these occur, the child should be asked if he is afraid something might happen and then be told that it is safe to talk about his fears. In addition, the parent should be encouraged to let the child talk about his dreams and what he thinks different parts of the dream mean. If this doesn't decrease the traumatic symptoms within a few days, a mental health consultation referral is in order.

Depression

Although many depressed children exhibit symptoms similar to those of adults—such as feeling down, diminished interest or pleasure in activities, insomnia/hypersomnia, psychomotor retardation, fatigue, feelings of worthlessness, difficulties in concentration, and suicidal ideation—there may be developmental differences in how the symptoms are expressed. For example, children may fail to gain weight, and irritability or conduct problems may take the place of feeling "blue."

In fact, many children who are referred to primary care doctors for behavior-related problems in school, such as fighting or failing classes, are depressed. While symptoms like these can be reactions to familial situations, they may also indicate a major depressive disorder that can be managed by a combination of antidepressants and psychotherapy. However, consultation with a child psychiatrist is recommended before considering medication, as is talking with the child and his parent to try to determine the root cause.

In all cases when symptoms of depression are present, primary care physicians should screen for suicidal ideation, even in children as young as four. This can be done by asking "Do you often feel sad?" and "Are some things you used to like not fun anymore?" If the answer to either of these is "yes," then a more detailed assessment should be made.

Substance Use Disorders

Many adolescents experiment with drugs or alcohol and consequently some develop severe disorders related to substance

> PEACEFUL POSSE

By Michael C. Reichert / Project Director, Peaceful Posse in Philadelphia, Pennsylvania. For more information on the Peaceful Posse program, contact Herb Levine, development director, at herbposse@aol.com.

At Peaceful Posse, we believe that "hurt people hurt people." Without the opportunity to avail themselves of the processes of healing, children who have been hurt by their exposure to violence—either directly as victims or indirectly as witnesses—will endlessly reenact the traumas they have experienced. Peaceful Posse is dedicated to the proposition that all children deserve a chance to envision their lives free from distress. As a division of Philadelphia Physicians for Social Responsibility—itself an affiliate of an international organization that shared a Nobel Prize in 1985 for its work on the public health consequences of the nuclear arms threat—Peaceful Posse represents a commitment to children, to families, and to communities. The program forms and facilitates groups for children; offers training programs for men and women eager to learn skills that can improve their work with children; establishes partnerships with community groups, such as public health clinics, recreation centers, and schools; and conducts ongoing research to ensure that we accomplish what we set out to do.

Peaceful Posse pairs groups of 10-15 early adolescent boys and girls with a trained mentor who has been carefully selected for his or her motivation, ability to care for adolescents, and the respect earned within his or her individual community. Each mentor has completed a rigorous Peaceful Posse training program, including instruction in various tools of listening and healing drawn from the fields of trauma theory and the co-counseling model known as Re-evaluation Counseling. Peaceful Posse staff accept the idea that healing happens from "the inside out" and that men and women can only offer children what they themselves have experienced and practice in an ongoing commitment to skills-building and mutual support. Peaceful Posse group leaders meet regularly in supervision groups and the overall program is supervised by a

child psychologist with many years of clinical experience.

Children who come to Peaceful Posse groups do so primarily on their own, but there have also been many cases of mothers directing their sons into Peaceful Posse groups; health, school, or recreation center staff recruiting members for the groups; and older siblings bringing along their younger sisters or brothers to meetings. While Peaceful Posse has maintained an "open door" policy towards children, it has come to appreciate that "like moths to light," those children who self-select into our groups do so because they seek something from us. Our research has confirmed unfortunately high rates of exposure to street, school, and family violence among these children. Once settled into a relationship with a group leader, Peaceful Posse offers them a curriculum that includes four themes:

- attachment and community;
- trauma and healing;
- perspectives on power—especially race, class, and gender; and
- skills for peace.

Peaceful Posse feels strongly that safety for children occurs within their attachments to adults, as well as to each other, and that healing often requires little more than group norms, which offer permission and patient listening so that children can reveal and unburden themselves. The program emphasizes long-term relationships for children who have experienced far too much abandonment and loss. To this end, we do our best to insure that group members and leaders, once established, can continue indefinitely. It is not uncommon for children to remain in a Peaceful Posse group for over two years.

The curriculum for the children includes exploring perspectives on gender, race, and socioeconomic status because Peaceful Posse believes that violent behavior stems in a logical way from cultural oppression—oppression that must be understood in order to be challenged and dismantled. As long as any group hurts another, causing them to feel diminished and ashamed, the seeds of violence are sown. The program is particularly sensitive to the manner in which children build their self-concepts in the "looking glass" of social relations and that poor children, children of color, boys, and girls all internalize ideas about who they are and who they can become based upon social constructions, which can be quite limiting and hurtful. Our curriculum empowers children to free themselves from negative, internalized attributions.

The Peaceful Posse program includes special emphasis on gender because we recognize that many factors—poverty, exposure to domestic violence, community norms for peer group violence, substance abuse, absent fathers, patterns of child-rearing and parenting, and school failure, for example—place boys at high risk for becoming violent. In Peaceful Posse groups, boys are invited into a relationship with a man who cares for them and helps them to bond with each other. Together they consider paths to manhood that are based on both helping oneself and contributing to the community, as opposed to ones based on power and domination.

In the United States, girls seem increasingly to be drawn into patterns of violence. Recent studies of girls' health that show how common victimization is for young women may partly explain this growing trend. Additionally, we see that as girls step out of oppressive roles, they sometimes adopt stereotypically male patterns of violent behavior. In Peaceful Posse groups, girls meet with a mentor who helps them heal from hurtful experiences, establish a supportive peer culture to stand against negative pressures, and claim a healthy pride in their identities as women.

In addition to this work, certain skills such as anger management, interpersonal problem-solving, critical media viewing, emotional literacy, and drug and alcohol awareness are taught in the fourth theme of the curriculum. The adolescents learn to apply these new skills to their interpersonal relations once they are free from the compulsion to reenact their own pain.

Based upon the success of this model with young people, Peaceful Posse has had the opportunity to offer training to other agencies and community groups working with adolescents. Men and women who have earned their community's respect and trust as youth leaders are recruited by these agencies as they aim to increase the number of "willing hearts" available to young people. Through an intensive and experientially demanding, year-long training program, these individuals are given the support necessary to become Peaceful Posse mentors. Our mentor training programs offer educational and emotional preparation for working with adolescents. We teach strategies for helping children heal from traumatic experience and for managing interpersonal conflicts. The Peaceful Posse training program explores how mentoring relationships can help children resist pressures to be violent, and we provide a larger context to help mentors identify how cultural factors such as gender, race, and class can foster conditions that exacerbate trauma and lead to violence in relationships.

We ask applicants to these training programs to speak confidentially about their personal struggles, to share their own histories with violence, and to talk about their present attitudes toward children and child-rearing. Our experience teaches us that to become maximally effective as mentors, adults must be able to maintain empathy for children. This often requires that they be willing and able to remember and heal from their own difficult experiences of youth. To meet these goals, we offer an intensive curriculum in peer-counseling skills, which offer all trainees the experience of healing from "the inside out" and which helps them to understand the naturalness of emotional expression and self-healing.

Through the training they receive and the curriculum they provide, Peaceful Posse group leaders endeavor to offer children freedom from psychological compulsion and antisocial actions. Independent evaluations of our progress indicate that these efforts can pay off in significant changes in basic attitudes and predispositions toward violence. In our years of experience, we have found that children want to contribute to their community's progress. Hurt and overlooked, they can be trouble; attended to and guided, they are our hope. ■

abuse. When seeing teenagers, physicians should always ask about substance use, as it can be a good opportunity to prevent later problems. Symptoms of substance abuse include recurring inability to fulfill major obligations at work, school, or home, as well as taking unusual risks—driving while intoxicated, for example—and/or persistent legal or interpersonal problems. Dependence requires that at least three of the following be present:

- tolerance of the substance—drug or alcohol—which is defined as either a need for markedly increased amounts of the substance to achieve intoxication or the desired effect or a markedly diminished effect with continued use of the same amount of the substance;
- withdrawal manifested by either the development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged—for example, hand tremors, nausea, vomiting, or anxiety—or clinically significant impairment of social, occupational, and other important areas of functioning;
- taking increasing amounts of the substance over time;
- a persistent desire or unsuccessful efforts to cut down or quit using the substance;
- a great deal of time spent obtaining the substance;
- giving up important activities in favor of being high or intoxicated;
- or continued use even with the knowledge that recurrent physical or psychological problems are caused by the substance.

A physician can help a teenager by first encouraging them to recognize that he has a problem and getting the family involved in the situation. If this fails to stop the substance abuse, then referral for treatment is necessary. The high prevalence of substance abuse in the NIS makes screening for these types of problems by pediatricians and primary care doctors a very important element of prevention. If a problem is identified, a physician may use several motivational techniques to address it, such as encouragement, advice with feedback from results of tests or medical exams, goal setting, and/or providing choices and referrals for various treatment options

Conduct Disorders and Behavior Problems

Children who persistently violate the rights of others through either verbal or nonverbal aggression, destruction of property, deceitfulness, theft, or serious breach of rules may meet the criteria for having a conduct disorder. Physicians need to be careful to distinguish between behaviors that might be better explained by depression, attention-deficit hyperactivity disorder (ADHD), or a reaction to child abuse.

Conduct disorders beginning in early childhood are strongly associated with family discord and disruption.[5] Because of this, a first course of intervention by a physician is to determine whether family conflict is present and, if so, to get the family into counseling. In addition, a physician should ask about child disciplining practices and counsel families on ways to help control the child's behavior. If this approach is unsuccessful, then the best course of action is to refer the child to a mental health specialist for a more complete assessment.

Attention-deficit Hyperactivity Disorder

In the United States, the most common mental disorder among school-age children is ADHD. Current rates of this problem in the NIS and CEE are not available. ADHD often manifests itself around the ages of 6-7 when a child starts school and its symptoms include inattention, hyperactivity, impulsiveness, difficulties organizing tasks, and low tolerance for frustration. Methylphenidate (Ritalin) is the most commonly used treatment for ADHD—although behavioral management or working with parents to improve their parenting skills may help. While there has been some controversy about prescribing Ritalin, recent research has shown it to be quite effective for children who have been appropriately diagnosed.[6] Primary care physicians who are uncertain about whether a child indeed has ADHD should refer the child to a child psychiatrist.

Common Causes of Mental Disorders and Behavior Problems

Children are born with various temperments and may be biologically predisposed to developing conduct and behavior problems. However, there are a number of family situations that may contribute to the onset of symptoms. Below are some of the more common family problems that can contribute to children developing behavioral and emotional difficulties.

Maltreatment

Children of any age, race, gender, or socioeconomic class can be victims of maltreatment. Child abuse and neglect (CAN) has been recognized as a major global public health problem. Recent estimates from the World Health Organization show that, worldwide, 40 million children up to the age of 14 suffer from abuse and neglect and require health and social care.[7]

Fatal abuse or neglect may be chronic and/or repeated—for example battered child syndrome or failure to provide medical care—or a single incident of assault, such as through drown-

SCREENING FOR CHILD ABUSE AND NEGLECT

In most countries, primary care physicians do not investigate child abuse and neglect. Physicians need to know local child protection regulations and know how much they may ask, as well as when and to whom they must report for further investigation. In most cases, however, there are some general questions that can be asked.

If a physician suspects child abuse and neglect, he or she should interview the child preferably without the parents in the room. The most common questions to ask are the following:

- Has anybody ever touched you in a way that you didn't like?
- Has anybody ever hurt you?

If the answer is "yes" then ask the following questions:

- Where did they touch/hurt you? (if they can't answer, then have them point to the part of their body where it happened)
- Did they do it more than once?
- Who hurt you or touched you there?
- What did they do?
- When did they do it?
- Did they say anything to you when they did it?
- Did you tell anybody about it?

Other questions you might ask are listed under each of the sections below.

PHYSICAL ABUSE

Physical abuse is defined as inflicted acts that cause physical injury to a child by a parent or caretaker or the risk of such injury. These injuries can include those that result from punching, beating, kicking, shaking, burning, biting, strangulation, or immersion in scalding water, such as bruises, welts, broken bones, scars, burns, retinal hemorrhage, and internal injuries. Physical abuse may be present when:

- the history given by a parent does not match the injury;
- the child gives unbelievable explanations for injuries;
- the child reports being injured by a parent; or
- the child fears going home or requests to stay at the school, daycare, or hospital.

Physical abuse often occurs as part of physical discipline by a parent. Primary care practitioners may ask about discipline strategies used by parents. Questions such as "What kind of discipline do you use, what works best?" and "What has been most serious/severe discipline you have ever used?" are appropriate. Physicians may provide a parent with information on child development and age appropriate discipline, as well as give a referral to parent counseling.

SEXUAL ABUSE

Child sexual abuse is defined as sexually motivated behavior by an adult involving a child, or sexual exploitation of a child. It includes sexual penetration, touching, fondling, rubbing oneself against a child, voyeurism, exposure, child prostitution, and production of pornographic materials. Sexual abuse may be present when:

- there is injury to the genital area or other medical indicators of sexual activity such as frequent, unexplained sore throats or yeast or urinary tract infections;
- diagnosis of a sexually transmitted disease;
- pregnancy in a young adolescent; or
- knowledge that the child is engaged in prostitution.

Other possible symptoms/behaviors that may raise concern of possible sexual abuse may include but are not limited to:

- a child engaged in highly inappropriate sexual behavior or
- history of somatic complaints, including pain or irritation of the genitals.

To be able to respond appropriately in such cases, physicians need to have knowledge of normal child development—including possible sexual behaviors—as well as be aware of legal aspects and procedures in cases of child abuse and neglect that have been established nationally and locally.

NEGLECT

Neglect is defined as the chronic failure of a parent or caretaker to provide for a child's basic needs, protection, and supervision, which result in significant harm or the risk of significant harm to the child. This includes medical, educational, and physical neglect, such as failure to provide food, clothing, shelter, and adequate supervision and protection from hazards. Neglect may be present when a child

- is significantly below the average height/weight for his age;
- wears inappropriate clothing for the weather;
- lacks a safe, sanitary place to live;
- lacks necessary medical and dental care;
- reports that there is no caretaker in the home;
- has an untreated illness or injury;
- has poor hygiene, including lice, body odor, and scaly skin; or
- is abandoned or left with inadequate supervision. ■

ing, suffocating, or shaking a baby. Determining the actual number of children who die because of CAN is complex, but it is generally accepted that infants are at most risk of a fatal injury. The numbers are often underestimated due to a bias among doctors and coroners to find natural causes for death. Some deaths labeled as accidents or illness-related might be attributed to child maltreatment if more comprehensive investigations were conducted. For primary care physicians, it is difficult to distinguish a child who was dropped, pushed, or thrown from a child who dies from an accidental fall, or a child who has been suffocated from a child who has died as a result of sudden infant death syndrome (SIDS). Lack of medical, law enforcement, and social protection standards for death investigations lead to an inconsistent response to the problem.

Despite variations among professionals from different disciplines and countries, there is some consensus on definitions related to CAN. For working purposes, child maltreatment is commonly divided into four categories: physical abuse, sexual abuse, neglect, and psychological maltreatment (see sidebar for definitions). There is little empirical data concerning rates of child maltreatment in the NIS and CEE; however, in the United States in 1998, it was estimated that there were 903,000 victims of child maltreatment or 12.9 victims per 1,000 children. The highest victimization rates were for those in the birth-to-3 age group: 14.8 per 1,000 children. Rates declined as age increased, and of these 903,000 children, 54 percent suffered neglect; 23 percent were physically abused; 12 percent were sexually abused;, and about six percent each suffered from medical neglect or emotional abuse.[8] In addition, 25 percent of the children were reported to be victims of more than one type of maltreatment.

Existing data on incidence of child abuse and neglect in Eastern Europe is difficult to compare because established national/regional data criteria and availability are lacking. Data seems to be characterized more by what agencies are experiencing in CAN than by the extent of actual CAN cases in a given country.[9] Based on available health indicators and limited data regarding violence in East European countries, it may be expected that the numbers of CAN cases in these countries are not lower than in the United States and that CAN cases are probably underreported in countries that participated in the 1998 National Humane Society survey.

According to police reports, the number of criminal offenses in which "young persons" were the victims is more than 17,000 per year in Russia. Sexual violence against girls and boys under the age of 15 accounts for 30 percent of all crimes in this category; it is more often children between the ages 8 and 12 who are attacked. The perpetrators are known to their victims in 50 percent of all cases, with roughly 40 percent of the crimes being committed by relatives.[10] Many experts believe that sexual abuse is the most underreported form of child maltreatment because of the secrecy or "conspiracy of silence" that so often characterizes these cases. The data of the survey reveals that the number of child sexual abuse cases that comes to the attention of agencies is extremely low.

In Croatia, 3,500 children in 1990—or 3 per 1,000—were treated by social welfare agencies because they suffered from abuse or neglect. It is estimated that the number of actual cases significantly exceeds the number of those reported.[11]

A study that raised the problem of abuse and neglect of children by alcoholic fathers in Bulgaria found that the majority of such fathers—83 percent—were aggressive, defined as verbally threatening and physically violent, toward their families. Children in these families demonstrated emotional problems as well as antisocial behaviors that increased over time. After eight to nine years of abuse, 61 percent of the children demonstrated antisocial behaviors versus the 39 percent who exhibited it during the initial evaluation.[12]

Concern about the physical abuse of children, along with the lack of an adequate legal or social protection infrastructure, was stressed by the author of a study on children admitted to pediatric surgery units in Poland. In a city of one million, two out of three existing pediatric surgery units identified 40 cases of severe bodily injuries inflicted by parents in one year.[13] Another study found evidence of childhood sexual abuse in Czechoslovakia. Of the 373 women interviewed, 16 percent reported that they were sexually abused by an adult male before menarche.[14]

When treating a child, doctors should always consider the possibility that a child's injury or illness may be related to abuse or neglect (see sidebar). If there is any suspicion of maltreatment, the physician should consider discussing the case with colleagues and making a referral to a child protection agency. In many cases, a physician can provide important preventive intervention by helping parents increase their knowledge of normal child development, increase their sensitivity to their child's needs, correct unrealistic expectations, and model positive approaches and problem-solving techniques.

Child protection systems, including reporting and investigation services, are not well established the CEE/NIS region. However, in some cases, a doctor may need to make a referral to a social agency, parenting group, counselor, or mental health

> PEER COUNSELING GIVES YOUTH TOOLS TO NAVIGATE LIFE

By Kathryn Utan / AIHA Staff Writer

Its really not easy to be a young person today, admits Natasha. "Growing up is always difficult, but I think my generation is facing many problems that our parents just didn't have to deal with," explains the 18-year-old native of Dubna, Russia.

The political, social, and economic uncertainties that marked the past decade, coupled with the normal turmoil that marks adolescence, have combined, leaving many young people in the formerly-closed city located 128 kilometers outside of Moscow with feelings of anger, confusion, and isolation. "There aren't a lot of alternatives or things to keep teens busy during their free time, so many of them turn to tobacco, alcohol, or drugs," Natasha continues, explaining that this, in turn, can lead to depression, further alienation, conflicts with family, friends, and teachers, and even violence and criminal activity.

Natasha's observations are as perceptive as they are accurate, according to Eugeny Alexandrov, a substance abuse specialist and social worker at Rebirth Center, an alcohol and drug rehabilitation facility that was established through the efforts of AIHA's Dubna/La Crosse partnership. "We began to notice a disturbing rise in levels of violence, petty crime, and substance abuse among teens and young adults in our community, so we decided to create a program that targets the root of the problem itself—disenfranchised youth," states Alexandrov, who is also vice principal of School No. 7 in Dubna.

"We established a Conflict Resolution School in September 1998 to help teens learn how to resolve difficult situations, and communicate more effectively with their peers and authority figures. We also wanted to give them a healthier, more productive alternative to crime, substance abuse, and violence," he explains, noting that the city health department, municipal and school administration, local media, and law enforcement agencies have all been very supportive of the project.

"The goal of the school is to teach children the basics of conflict resolution, which include cooperation, communication, respect, and the ability to express emotions in a positive, productive manner," Alexandrov points out. "By taking part in simulations and role-play exercises, the children learn to apply these basic interpersonal skills to their own relationships. It's a step-by-step way for them to discover how to live a better life by first getting to know themselves, then learning how to analyze difficult situations rationally and make appropriate, mutually acceptable decisions."

SIX IMPORTANT STEPS TO CONFLICT RESOLUTION

1. Define the problem.
2. Listen to all sides then come up with possible solutions.
3. Evaluate the possible solutions.
4. Adopt a solution that is acceptable to all parties.
5. Execute the solution.
6. Evaluate the results of the solution.

At Dubna's Conflict Resolution School, children and young adults learn a variety of strategies for dealing with problems they have with friends, family, peers, or authority figures such as teachers and the police. Using these six key steps, almost any kind of conflict can be successfully resolved, according to program coordinator Eugeny Alexandrov.

At first, Alexandrov and Natalia Semenova, one of his colleagues at Rebirth Center, taught small classes of high school students how to better cope with conflicts and the day-to-day problems they encountered. Then, as these earliest Conflict Resolution School " graduates" became more adept at the strategies, some of them were chosen to become peer counselors.

To be a peer counselor, explains 18-year-old Dmitriy, one must have successfully completed the classes at the Conflict Resolution School, be willing to commit a significant amount of time and energy the project, be able to communicate well with others, and be highly motivated. Now studying at the University of Wisconsin in La Crosse, Dmitriy was a peer counselor for more than a year. "The whole idea of the School is to get together people from a wide variety of backgrounds to teach them how to cope with their problems and avoid falling into the mistaken idea that alcohol or drugs will make any trouble they have—with their parents, with school, with any other part of their lives—go away. Then they pass this information along to their friends," he says.

Students of the School meet once a week for an entire semester and there are about 25 or 30 teens in each class, Dmitriy notes. "Because the Rebirth Center is the basis for the Conflict Resolution School, a lot of our work focuses on helping kids avoid substance abuse. For this purpose, peer education is very important. If an adult tells a kid not to smoke, for example, he will most likely start smoking. But if someone who is the same age tells that kid that smoking is dangerous and not a ëcool' thing to do, he probably won't feel the need to start—especially if he hears it from a number of his friends."

Since 1998, more than 350 high school students have received training at the Conflict Resolution School and numerous other adolescents from local children's camps, orphanages, and primary schools have participated in education programs taught by Alexandrov and the team of peer counselors.

"After taking part in the classes, I started to understand life better and wasn't so afraid to admit it when I had a problem and ask for help or advice," Dmitriy attests. Sergey, 18, agrees that learning how to cope with his problems has had a big impact on his life. "I am much more sociable now and have been able to make a many new friends," he explains. For 19-year-old Tanya, the program has helped her build poise and self-esteem. "I am very comfortable dealing with people of all ages and feel that what I have learned has really helped me develop the skills I need to overcome conflicts with the people in my life."

The School has had a significant impact on many young lives, Alexandrov concludes, and many of the teens readily admit that he is right. ■

professional or take other actions that have been established in local medical/child protection/legal systems for such cases. Serious concerns regarding a child's safety should lead to an emergency referral to a child protection/custody specialist, hospital, and/or the police to determine if child abuse or neglect is present.

It is known that head injury is one of the most dangerous types of injury, and a leading cause of death in abused children, particularly young children. One type of head injury, shaken baby syndrome (SBS), receives little recognition in the NIS. It includes a constellation of symptoms caused by the violent shaking of an infant or small child that results in the child's brain moving within the skull, causing blood vessels to stretch and tear, leading to subdural hematoma (intracranial bleeding), brain swelling, and retinal hemorrhages. SBS causes brain injury, coma, or death. It is important to note that SBS often occurs when a frustrated caregiver loses control with an inconsolable crying baby. Doctors should educate parents on SBS and pass the message about the danger of shaking an infant on to caregivers.

Domestic Violence

Children who have parents who are verbally or physically abusive toward each other may observe a violent act or see the results of an assault, and fear for the assaulted parent or relative, as well as for themselves. Children exposed to domestic violence may exhibit a variety of problems such as anxiety, delinquency, and substance abuse. These children are also more likely to experience direct abuse and neglect. (For examples of screening questions, see the sidebar. The first goal of a physician who suspects domestic violence is assuring the child's safety.) Victims of domestic violence usually feel powerless and isolated. Providing support and knowledge—such as information on women's organizations, hotlines, shelters, and emergency phone numbers—may help a victim break the cycle of violence and provide safety for the victim and the child. (For more information, see "Understanding Intimate Partner Violence as a Physical and Mental Health Issue," *CommonHealth*, Fall 2000, pages 34-38.)

Divorce

Children whose parents are going through a divorce may display a number of behavior problems that, although often transient, can lead to more serious difficulties in the future. Divorce may bring about symptoms of anxiety and depression such as poor concentration, conduct problems in school, irritability, and nightmares. A primary intervention is having the physician explain to both parents, if possible, that to prevent the development of behavioral reactions to a divorce it is best to create a non-hostile working relationship in which to care for the child. This includes trying not to express hostility toward each other in front of the child and assuring the child that they will work together to take care of the child, even though they are divorced. If a child's symptoms continue, referral to a mental health practitioner is warranted.

Parental Substance Abuse

Like children exposed to other types of parental conflict, children of parents who abuse substances may display a whole range of behavior problems. Depression, anxiety, and conduct problems are the disorders most commonly seen in this scenario. Children whose parents are substance abusers are also more at risk for neglect or physical abuse than their peers. ■

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