Improving mental and behavioral health care for children has become a national priority, both as an important aspect of medical home care delivery and in response to recent tragedies that highlight the importance of addressing mental health. Efforts to improve pediatric mental and behavioral health care within primary care practices usually focus on trying to better implement best practices for diagnosing and treating the most common mental health disorders — like attention-deficit/hyperactivity disorder, depression, anxiety, and the disruptive behavior disorders. In this issue, we look at how to improve the mental and behavioral health of children, but this time move the focus away from the “greatest hits” section of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) and toward other ways we can support healthy emotional and behavioral development.

Bullying has been recognized as both an extremely common part of childhood experiences and one that often has very negative long-term consequences on both mental health and life functioning. For instance, when peer-to-peer school violence occurs, communities have learned to immediately question if bullying had been a contributing factor. Efforts to better identify and intervene with childhood bullying have typically focused on what schools should do (such as “no tolerance” policies) and on public education efforts, but there has been less clarity on what medical professionals can do to halt the cycle of bullying.

In this issue, David Buxton, MD, Mona Patel Potter, MD, and Jeff Q. Bostic, MD (see page 154) describe not only the basics of what constitutes bullying and describe its consequences, but they also go on to helpfully recommend both screening and intervention strategies. Although as clinicians, we cannot halt the cycle of bullying on our own, we can certainly learn how to be active agents for change.

Munchausen syndrome by proxy, which is now often referred to as “medical child abuse,” is thankfully an uncommon behavioral health-related problem. However, when it does occur, it has wide ranging negative impacts on both the children involved and on their whole families. Usually, it is the primary care provider who first identifies such cases and finds themselves embroiled in both systems and family conflicts, making it difficult to negotiate a best outcome for the child through the denials and accusations that can arise. Janet E. Squires, MD, and Robert H. Squires, MD (see page 155) describe in their article the current understanding about this problem, and the systems and care issues that arise to help us better negotiate these situations, and support primary care providers.

Neglect of children has become increasingly recognized as another problem with long-term consequences. Neglect is more difficult to define and identify than outright physical abuse, but it is no less important. In my own work, I regularly see that ne-
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glect has caused pervasive negative impacts on mental health, personality development, future psychosocial functioning, and that it may have also caused problems with both physical health and development. In this issue, Harold Dubowitz, MD (see page 156) discusses the waterfront of neglect problems in children and offers a series of concrete suggestions for both assessing and intervening effectively in cases of neglect.

The decision of whether or not to prescribe a selective serotonin reuptake inhibitor (SSRI) for a child is often a difficult one to make as a primary care clinician. The US FDA warnings about the potential for increasing suicidality; physician doubts about when the medications are appropriate or about their potential clinical effectiveness; and unfamiliarity with reasons why one might select one SSRI over another are just a few of the reasons why this class of medications can be challenging. In this issue, David R. Camenisch, MD, and myself (see page 157) discuss these and other aspects of SSRI use in children to address concerns that may arise when an SSRI prescription is being considered.