Core Functions of Communication in Pediatric Medicine: An Exploratory Analysis of Parent and Patient Narratives

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Abstract

Communication in pediatrics is important for psychological well-being and health outcomes. However, consensus is lacking regarding the core functions of communication in pediatrics. The aims of this study were (1) to evaluate whether and how core communication functions from adult oncology apply to communication in pediatric medicine and (2) to examine whether any unique core communication functions exist in pediatric medicine. We analyzed 36 narratives written by parents (n=23) or patients (n=13) describing pediatric communication experiences with clinicians that were published in *Narrative Inquiry in Bioethics*. Utilizing deductive and inductive coding, we evaluated narratives for evidence of core communication functions previously documented in adult oncology. We also evaluated for novel functions not represented in adult oncology. We identified the presence of all adult core communication functions in pediatric narratives. We also found evidence of a novel function, “engendering solidarity and validation.” We report clinician behaviors that appeared to facilitate or impair these core functions. Core communication functions in adult oncology apply to communication in pediatric medicine, but we also identified a novel communication function in pediatrics.

Keywords

communication; pediatrics; patient reported outcomes

Introduction

Communication between clinicians and families serves several functions in pediatrics, and effective communication is critical to improving healthcare delivery and outcomes.[12, 19] Parental perception of high-quality physician communication has been associated with parental peace of mind,[13] hopefulness,[15] feeling acknowledged[1] and comforted[25],

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and greater trust in the physician.[6] High-quality information sharing has been associated with parents being better prepared for self-management[23] and fulfilling their preferred role in decision making.[14]

In 2007, the National Cancer Institute convened an expert committee that identified six core functions of communication in adult oncology: (1) exchanging information, (2) making decisions, (3) fostering healing relationships, (4) enabling patient self-management, (5) managing uncertainty, and (6) responding to emotions.[7] The project was conceptually grounded in a functional model of communication, in which the focus is on outcomes rather than specifically the process of communication.[24]

In contrast to adult oncology, communication in pediatrics is triadic (parent-child-clinician), which creates unique needs for both parents and children. While communication in pediatrics likely shares many commonalities with adult oncology, we hypothesized that pediatric communication has unique functions not fully represented in adult oncology. Additionally, some adult communication functions may not apply equally in pediatrics. Understanding how communication functions in pediatrics is essential to inform the development of communication interventions. Currently, there are no studies that have explicitly aimed to identify the core functions of pediatric communication.

In this exploratory study, we evaluated 36 narratives from parents and patients who were reflecting on experiences in pediatrics. These narratives were published in the journal *Narrative Inquiry in Bioethics* (NIB) as part of topicspecific symposia. Personal narratives provide insight and enhance understanding by compelling readers to consider the writer's viewpoint, decision-making process, and emotions.[17] Narrative provides a mechanism to access the lived experience of others, demonstrate a range of sentiments, and may express calls for change,[21] making them especially useful for our purpose of eliciting communication functions that may often be tacit, implicit, and not openly acknowledged. Analyzing first-person narratives provides insight into communication functions and challenges that is distinct from recorded conversations or interview data. In each of the symposia, narrative authors were asked to describe what went well in the clinical setting, what went badly, and what they would want to share with healthcare providers or patients who are similarly situated.

Methods

Our primary aim was to determine if the 6 communication functions in adult oncology apply to experiences of pediatric communication. Secondly, we aimed to identify any novel communication functions apparent in pediatric narratives. Data were derived from 36 narratives written by either parents or patients reflecting on communication experiences with physicians from childhood. The narratives were published in the journal NIB. We included for analysis all narrative published in NIB between journal founding (2011) and May 2017 that included parent or former pediatric patient perspectives on adolescent or pediatric medicine encounters. Five issues of NIB were utilized because they contain descriptions of pediatric communication: Issue 4.1 with parent stories about confronting pediatric brain tumors [16]; 5.2 with stories from those who are intersex [4]; 6.3 with parent stories about

choosing to vaccinate their children or not [3]; 5.3 with patient and research participant stories about their experiences with genetic testing [5]; and 7.2 with patient stories about cancer and its effects on fertility. [11] Subsequent quotations in this manuscript will reference these issue numbers.

We used a combination of deductive (to identify the presence or absence of core functions from adult oncology) and inductive (to identify clinician behaviors that support communication and novel functions) coding strategies.[20] The initial codebook was developed based on our prior work,[22] and definitions underwent minor revisions as coding proceeded. (Table 1) In the first stage of deductive coding, two coders (BAS, AF) coded all narratives to determine the presence or absence of the adult core functions. Coders were blinded to each other during coding. Each excerpt was coded with the single function that was best represented, and disagreements were resolved through discussion between the two coders. Inter-rater reliability was established using the Dedoose training center, and through iterative discussion, until a kappa of >0.8 was achieved. The Dedoose training center allows one coder to identify and code excerpts. The second coder can then engage in training sessions (or tests) where kappa is calculated based on whether the second coder applies the same code to excerpts as the first coder. We evaluated kappa during codebook formation, and we performed two kappa checks throughout coding to ensure kappa remained >0.8 . One coder (BAS) then reviewed all coded excerpts to identify clinician behaviors that demonstrated the coded function.

This deductive coding was supplemented by exploratory inductive coding for evidence suggesting novel communication function(s) distinct from the adult core functions. We found evidence of a novel function “engendering validation and solidarity.” This function was initially identified in intersex narratives only. In order to determine if this function might be unique to particular populations, such as those who have stigmatized conditions like intersex, one coder (BAS) subsequently reviewed all narratives to determine if other narratives contained evidence of this novel function (see results).

Results

We analyzed 36 six narratives, 23 written by parents and 13 by patients. (Table 2) We identified evidence to support all of the adult core communication functions in pediatrics. We also found evidence to support a novel function, “engendering solidarity and validation.” We report clinician behaviors that facilitated or inhibited these core functions, with the goal of providing examples to further elucidate the communication functions. In Table 3 and in what follows, communication functions are presented in rank order based on number of narratives containing codes for each function.

Fostering Healing Relationships:

“Fostering healing relationships” was identified in 27/36 narratives, evidenced by 4 clinician behaviors. The first behavior was “honestly disclosing difficult information.” Parents and patients felt a sense of distrust when they suspected their clinicians were not disclosing all

pertinent information. For instance, pediatric patients commented on the “psychological trauma” of deception:

“While I have no doubt the medical providers involved thought they were protecting me (and my parents) by hiding a perceived shameful truth about my body, I believe it was wrong to replace the truth with lies that perpetuated my fear of cancer and forced me to imagine much more radical versions of ‘my truth.’”

(Issue 5.2)

The second behavior was “communicating empathically and respectfully.” Some narratives highlighted positive behaviors, such as attentiveness, kindness, and respectfulness. Others identified clinician behaviors that impeded the development of a healing relationship, such as insensitivity, inappropriate or uncomfortable comments, “talking about me like I was not present,” and unkindness. The clinician’s tone of voice also affected the perception of empathy:

“Thinking back on that month, we cannot be sure what stopped our research on reproductive endocrinologists after meeting Dr. B, but hers was the only consultation we needed. Perhaps it was Dr. B’s steady voice, her intuitive empathy, her straight-forward analysis of our situation, and her readiness to engage with the rest of our medical team and family. Dr. B relayed this incredible medical acumen we could not have imagined was available or necessary, with the emotional tone of a peer, or even someone we might have known our whole lives.”

(Issue 7.2)

The third behavior was “seeking understanding and avoiding assumptions,” as demonstrated by a clinician employing active listening with the parent of a child with a brain tumor:

“Since our doctor had been unresponsive to my concerns, I made an appointment with another doctor. I told my husband that if the new doctor is just as unconcerned about our daughter’s gross motor skills, then I would let it go. The new doctor refrained from making judgments about my parenting skills and concerns. She listened carefully as I described the situation.”

(Issue 4.1)

The fourth behavior was “demonstrating clinical competence.” Trust was contingent on confidence in the skills and acumen of the clinician. This trust eroded when information was revised over time by the clinician, especially when parents did not understand why the information had changed.

Exchanging Information

“Exchanging information” was identified in 26/36 narratives, evidenced by 1 clinician behavior. This behavior was “transparently disclosing information”. Some narratives detailed complete disclosure of difficult news: “Every medical professional was very straight-forward with us that without insurance coverage, our fertility preservation procedures and genetic testing of embryos would be no small financial undertaking.” (Issue 7.2) However, other narratives highlighted examples of omission or deception regarding

diagnosis and prognosis. In some instances, this omission resulted in partial disclosure: “At some level, I knew I was not being told the whole truth. My parents’ and the doctors’ actions signaled to me something more might be going on. But I was afraid to ask questions; my parents were distressed and I didn’t want to cause them any more pain.” (Issue 7.2)

Although narratives consistently highlighted the importance of truthful disclosure, some parents and patients struggled with receiving difficult news, suggesting that full disclosure, even when desired, can temporarily hinder the ability to comprehend information. The following terms were used by parents and patients to describe the aftermath of disclosure: “worst day of my life”, “in a state of shock”, “I couldn’t even concentrate on what the doctor was saying,” “drowned in information”, “silent, frozen in the moment”, and “you don’t (can’t) hear half of it anyway.”

Making Decisions

“Making Decisions” was identified in 25/36 narratives, evidenced by 4 clinician behaviors. The first behavior was “supporting shared decision making.” Several narratives highlighted examples of shared decision-making, in which clinicians sought to understand the family’s values, provide sufficient information, offer guidance or recommendations, and collaborate in decision-making:

“A meeting to discuss how to care for my child if an acute crisis presented was held. The meeting included her parents, oncologist, endocrinologist, pediatric neurologist, social worker and the head of medical ethics. We discussed what course of action would be best for her [since] nothing could be done to reverse her condition or prevent further deterioration.”

(Issue 4.1)

In other narratives, clinicians made recommendations before seeking to understand the family’s healthcare related values, or clinicians seemed to allow rather than support the parental role in decision-making. “They did not know what she had but encouraged me to start vaccinating her. I asked to wait till she was better and with disapproval they reluctantly agreed to wait.” (Issue 6.3)

In contrast, some parents desired the clinicians to take a more active role in decision making:

“We were in shock and no other hospital staff person came to counsel us, guide us, direct us, comfort us after the neurosurgeon left the room. That was the worst night of my life. So, the decision was left up to us. We were confused. We just went numb. We were paralyzed with fear. We still had a child to take care of and get through the night. Here was this huge hospital with thousands of employees and no one there to tell us how to navigate these terrifying waters.”

(Issue 4.1)

The second behavior was “supporting informed consent.” While some narratives demonstrated clinicians offering limited information or treatment options to families, others demonstrated high-quality informed consent processes:

“My family completed the extensive consent process for the challenge. The researcher explained both in writing and in phone interviews about what it entailed, what the risks were and exactly what results would be reported and not reported back to us. My son, age 10 at the time, had to explain in his own words his understanding of the research to give his assent.”

(Issue 5.3)

The third behavior was “allowing time for decision making.” Time pressure was distressing for families who were making difficult decisions. Some urgency was medically necessary, but some appeared contrived for the clinician’s convenience:

“The day of the surgery came and I was being prepared for anesthesia. The doctors came into the room to tell me what was going to happen next. ‘We noticed that your vagina is smaller than other girls’. While we’re in the operating room fixing your urethra, we can also make a small incision in your vagina to make it larger. This way, you’ll be able to have sex with your husband when you’re older—Does that sound good?’ I looked at my mom, who was in the prep room with me for this and wondered how to answer. I was only 11. I let out a shameful, ‘Yes.’”

(Issue 5.2)

The fourth behavior was “providing consistent messages.” Several parents felt confused and frustrated when multiple medical teams disagreed with each other, or when the explanations from their medical team changed over time.

Managing Uncertainty

“Managing uncertainty” was identified in 17/36 narratives, evidenced by 3 clinician behaviors. The first behavior was “addressing and allowing room for uncertainty.” Some clinicians allowed room for uncertainty by employing a vocabulary of possibility: “Neurologists doubted he [our son] knew us. His doctors hoped Peter would recover but it was possible he would remain as he was indefinitely.” (Issue 4.1)

The second behavior was “managing expectations.” Clinicians managed expectations by providing insights or estimations about the future course of treatment or illness: “Since most children with DIPG are older and typically receive radiation treatment, the doctor was unable to give much direction on how the next few weeks and months would unfold. He opined that she would probably start to be more symptomatic shortly, but could not say for certain.” (Issue 4.1) Parents expressed frustration with excessive optimism, but also with excessive emphasis on negative outcomes. “I know his ophthalmologist was trying to prepare us for the worst, and to make sure he qualified for assistance, but he didn’t leave much room for the possibility that my son’s vision might be like all the other people in my family who may have variants of the same condition.” (Issue 5.3)

The third behavior was “demonstrating comfort with uncertainty.” The parents of a child with an undiagnosed genetic condition sensed their clinician’s discomfort with uncertainty: “We may know the mutation down to the base pair, but it seemed like it was hard for my

son's doctors to face anxious parents and offer a range of possible futures, admitting that we can't yet know what it will mean for this little boy." (Issue 5.3)

Enabling Patient Self-management

"Enabling Patient Self-management" was identified in 12/36 narratives, evidenced by 2 clinician behaviors. The first behavior was "providing referral to appropriate specialists and resources." Such referrals included those to subspecialist physicians, but several narratives also discussed the importance of referral to psychological resources and support groups:

"In retrospect, I wish counseling had been offered to me during my first meeting, or follow-ups, with Doctor A. Due to the absence of counseling recommendations or support group resources, I resorted to seeking information about intersex diagnoses on the Internet, which provided positive and negative search results."

(Issue 5.2)

The second behavior was "encouraging self-advocacy," exemplified by the experience of an intersex individual: "After my vaginal repair surgery, I had my first encounter with a truly compassionate and candid doctor, the surgeon who performed the repair. He coached me on how to find the complete truth about myself, and wanted to help me understand it." (Issue 5.2)

Responding to Emotions

"Responding to emotions" was identified in 6/36 narratives, evidenced by 2 clinician behaviors. The first behavior was "addressing emotion with sensitivity and patience." Some patients noted the importance of attention to emotional needs. For example, a child cancer survivor recalled how her oncologist called her parents at home to provide emotional support after a difficult disclosure: "Their devastation was so obvious that hours after delivering the news of possible infertility, my oncologist called my mom at home at 9:00pm that night to make sure she was okay." (Issue 7.2)

The second behavior was "recognizing the unique emotional needs of adolescents." One narrative written by a cancer survivor reflecting on her adolescence recalled her clinicians fulfilling this function: "At 16, in what I believe was the first time addressing me directly about it, my oncologist tried to broach the subject of my fertility. The outcome of the conversation, or lack thereof, was that I didn't want to talk about it. My care team respected my choice—we didn't talk about it." (Issue 7.2)

Engendering Solidarity and Validation

"Engendering solidarity and validation" was identified in 12/36 narratives, evidenced by 3 clinician behaviors. This communication function was most evident in intersex and pediatric brain tumor narratives. The first behavior was "alleviating feelings of abnormality." Nearly all narratives about intersex identified feelings of abnormality. Some of these narratives described clinicians taking steps to constructively address these feelings: "She examined me, concluding that my ovaries felt fine, that clitorises come in all shapes and sizes, and that she

thought mine was beautiful. By affirming the natural diversity in genital size, and referring positively to mine, this doctor undid the psychological damage done by the one who had deemed my genitals abnormal.” (Issue 5.2)

The second behavior was “addressing feelings of isolation or being alone.” Several narratives from the intersex symposium discussed the taboo and cultural stigma of their diagnosis. Parents in the pediatric brain tumor narratives also reflected on these feelings of isolation and being alone. For example, one parent offered the following advice to clinicians:

“[The medical team] could provide a list of most frequently asked questions of families who have been through the same situation. The person would also take the families “emotional pulse” by asking if they would like to talk about their fears, concerns or confusion. The family’s emotional trauma must be addressed on the day of diagnosis. The family needs to know and feel that they are not alone.”

(Issue 4.1)

The third behavior was “reinforcing parental perception of being a ‘good parent.’” Parents of children with brain tumors commented on their feelings of inadequacy as parents. Some clinicians missed opportunities to reinforce good parenting beliefs, while other acted in ways that exacerbated parents’ insecurities. For example, the parents of a child with a newly diagnosed, uniformly fatal brain cancer wrote about their agonizing decision not to pursue radiation treatment that would, at best, slow the progression of the disease but also potentially compromise their child’s last summer:

“When we met with the neuro-oncologist to discuss our treatment plan, he was visibly shocked that we had opted against radiation. He reiterated that radiation was the prescribed, and recommended, treatment for DIPG. His follow up notes stated three times, “Parents declined treatment” in a single page document. Partway through the meeting, when the doctor left for a moment, I remember turning to the other people in the room and saying, “Are we crazy? I feel like these doctors think we’re complete lunatics. Are we making a huge mistake? Is this decision wrong?”

(Issue 4.1)

Discussion

In this exploratory study, we identified evidence of all 6 communication functions from adult oncology in these pediatric narratives. We also identified a novel function not previously reported in adult literature: engendering validation and solidarity. This function represents the clinician’s role of addressing feelings of abnormality and isolation while reframing the family’s experience as being part of a larger group, and it was most apparent in narratives related to intersex and pediatric brain cancer. Pediatric literature on “good parenting” beliefs supports the existence of this function. Being a good parent can include many roles, such as ensuring the child feels loved, advocating for their child, making unselfish, informed decisions, and remaining at the child’s side.[10, 8, 18] Parents can suffer greatly when they blame themselves for not being a “good parent,” especially when their child is suffering.[2] We expect that this new core function of communication is relevant to adult medicine as well, particularly when communicating with surrogate decision-makers or

patients who make decisions that are unusual. However, this function might be less relevant or essential in adult medicine when compared to pediatrics. As such, it might be a function (but not a *core* function) in adult medicine.

Our findings support the need for further work to fully characterize these communication functions in pediatrics. These future studies should utilize discipline-specific populations in order to determine the presence and priority of these functions when applied to specific pediatric populations. For example, prioritization of communication functions may differ between pediatric oncology and pediatric primary care, with parents of children with cancer placing higher priority on engendering solidarity and validation or responding to emotions. Furthermore, these future studies should remain open to novel functions that may be discipline specific. By further characterizing these communication functions, future interventions can be designed to target specific deficiencies with the aim of improving communication and health outcomes. Few, if any, communication interventions have been developed in pediatrics.[22] Further research on the functions of communication in pediatrics will provide integral guidance to this developing field.

This exploratory analysis has provided important insights, but must be interpreted in light of its limitations. First, the narratives published in *NIB* might be more likely to reflect negative experiences, since individuals might feel compelled to write about experiences that went poorly to convey personal suffering or encourage change in practice.[9] However, the valence of individual narratives did not hinder the fulfillment of our study aims, namely to validate communication functions in pediatric medicine and to identify any novel functions. Our aim was not to evaluate physician practices, but rather to identify clinician actions that help to further elucidate the functions of communication.

Additionally, these narratives represent a heterogeneous group of pediatric disciplines. It is possible that communication functions have different priority depending on the clinical context and pediatric discipline. Therefore, this study sample cannot provide a balanced appraisal of the priority of communication functions in different pediatric subspecialties. Additionally, given the heterogeneous nature of our sample, we are unable to identify any differences in communication functions between parents and children. While it is possible that the two groups do not differ, we suspect minor differences might arise within more homogenous samples. As such, a deeper exploration of individual communication functions within specific pediatric disciplines might yield a more complete understanding of these communication functions. However, many functions were identified across this wide pediatric representation, suggesting that some communication functions might apply broadly in pediatrics and medicine.

Our findings support the presence of all 6 core communication functions from adult oncology in pediatrics, and we have identified a novel function specific to pediatrics. We also identified clinician behaviors that can facilitate or hinder these functions. Future studies should aim to identify the presence and prioritization of these functions within individual pediatric disciplines.

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Table 1.**Coding Definitions for Core Functions of Communication**

Code	Definitions of Communication Functions	Brief Definitions
Fostering Healing Relationships	Healing relationships provide emotional support, guidance, and understanding. Such relationships are built on trust, rapport, and mutual understanding of each other's roles and responsibilities. Physicians can facilitate a healing relationship by engaging in active listening, partnership building, seeking out goals and values of the patient and family, displaying warmth and empathy in communication.	Empathy and sensitivity to the needs of the patient, aiming to seek understanding
Exchanging Information	Patients and their families seek information about the cause, diagnosis, treatment, prognosis, and lasting effects of cancer and its treatment. Fulfilling information needs not only helps families to gain important knowledge about a child's illness, but also aides the development of a strong clinician-family relationship and supports decision making, among other outcomes. Patients and families also have information that they want to share with clinicians, so exchanging information seeks a bi-directional understanding between clinicians and families.	Specific instances of information being shared ("he told me this, nobody told me that, etc.")
Making Decisions	Effective decision making requires effective communication. Such communication can support decision making in a number of ways: raising the clinician's awareness of the family's needs, values, and fears; clarifying clinical reasoning and treatment options; alerting the physician to the family's preferred role in decision making.	Clinician specifically engages in the decision-making process and helps facilitates a decision
Managing Uncertainty	Parents and patients experience many types of uncertainty after a diagnosis of cancer. This uncertainty can pertain to prognosis, side effects, frequency of hospitalization, and long term effects, among others. Family-centered communication should help to communicate clinical uncertainty when it exists, dispel uncertainty when there is an answer, and help patients and families to manage unavoidable uncertainties. Parents and patients also identify uncertainties about possible future outcomes and communicate bi-directionally with clinicians to obtain anticipatory guidance for these uncertainties.	Pragmatic actions that clinicians take to manage uncertainty and address possible future outcomes (offering anticipatory guidance)
Enabling Patient Self-Management	Communication can also help patients to "enhance their ability to solve health-related problems and to take actions to improve their health." This can encompass recommendation, instruction, and advocacy.	Communication encourages patient/parent to seek out and utilize pragmatic resources (support groups, literature, etc.)
Responding to emotions	Patients with cancer can experience a range of emotions, including fear, sadness, anger, anxiety, and depression. When patients or parents express emotions in clinical encounters, the clinician's task is to recognize the emotional state, ask questions, communicate understanding, and respond with empathy or tangible help.	Some type of action oriented to patient's emotion (clinician holding a patient's hand, looking away when patient cries, etc.)
Engendering Solidarity and Validation	In difficult situations, patients want to feel as though they are not alone, that other people have been in this situation or have had to make similarly difficult decisions. Effective communication acknowledges that patients/families are part of a larger group and engenders feelings of solidarity and support. Communication also validates the current experiences of the patient/family.	Efforts to diminish feelings of abnormality and engendering shared experiences with a larger group

Table 2.

Characteristics of Narratives and Coding Results

Narrative Category	Number of Narratives	Codes Identified
Brain Tumors	15 (all parent perspectives)	<ul style="list-style-type: none"> Fostering Healing Relationships: 11 narratives Exchanging Information: 11 narratives Making Decisions: 11 narratives Managing Uncertainty: 8 narratives Enabling Patient SelfManagement: 3 narratives Responding to Emotions: 1 narrative Engendering Solidarity and Validation: 5 narratives
Cancer and Fertility	3 (2 patient perspectives, 1 parent perspective)	<ul style="list-style-type: none"> Fostering Healing Relationships: 1 narrative Exchanging Information: 3 narratives Making Decisions: 2 narratives Managing Uncertainty: 2 narratives Enabling Patient SelfManagement: 3 narratives Responding to Emotions: 2 narratives Engendering Solidarity and Validation: 0
Intersex	11 (all patient perspective)	<ul style="list-style-type: none"> Fostering Healing Relationships: 9 narratives Exchanging Information: 8 narratives Making Decisions: 8 narratives Managing Uncertainty: 3 narratives Enabling Patient SelfManagement: 5 narratives Responding to Emotions: 3 narratives Engendering Solidarity and Validation: 9 narratives
Vaccines	5 (all parent perspectives)	<ul style="list-style-type: none"> Fostering Healing Relationships: 5 narratives Exchanging Information: 3 narratives Making Decisions: 2 narratives Managing Uncertainty: 2 narratives Enabling Patient Self-Management: 0 Responding to Emotion: 0 Engendering Solidarity and Validation: 1
Genetic Testing	2 (parent perspectives)	<ul style="list-style-type: none"> Fostering Healing Relationships: 0 Exchanging Information: 1 narrative Making Decisions: 2 narratives Managing Uncertainty: 2 narratives Enabling Patient SelfManagement: 1 narrative Responding to Emotion: 0 Engendering Solidarity and Validation: 0

Table 3.

Rank Order of Communication Functions in Pediatric Narratives

Communication Function	Number of Narratives with Function Identified
Fostering Healing Relationships	27/36
Exchanging Information	26/36
Making Decisions	25/36
Managing Uncertainty	17/36
Engendering Solidarity and Validation	12/36
Enabling Patient Self-Management	12/36
Responding to Emotions	6/36