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Are pediatricians doing more family “therapy” than they realize? – changing families through single encounters

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Introduction

In the past decade, there has been an increasing recognition by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry of the need for pediatricians to improve competencies in assessing and treating behavioral health issues.¹ The increased efforts dedicated to pediatrician education in behavioral health has resulted in significantly improved access to mental health services.² A large proportion of children receiving services for behavioral health problems are now managed in primary care settings.³

Despite these advances, surveys of pediatricians have demonstrated that while many recognize their role in identifying behavioral health problems, there are many pediatricians who are not regularly treating these disorders.⁴ They may not see treatment as their role or they may feel they lack the expertise, and time to provide these services.⁴ Results of the American Academy of Pediatrics 2009 periodic survey revealed that less than one-third of the 1600 pediatricians surveyed saw it as their role to manage mental health issues beyond ADHD.³

Although some pediatricians don't feel prepared to provide behavioral health care or see this as their role, a number of researchers have pointed out that some pediatricians possess many qualities that make them well-suited to provide such services.¹ The medical home literature has also cited the value of providing behavioral and mental health services in the pediatric setting, where there is less stigma, high levels of trust, and more familiarity for families.^{1,2,5}

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A qualitative analysis of semi-structured interviews with families was conducted to understand the parents' expectations regarding the role of pediatricians in regards to behavioral health care. This qualitative analysis was part of a mixed-methods study of 55 parents whose children were referred for mental health care by their pediatrician; 36 of these 55 parents participated in a semi-structured interview. Parents were asked about their previous experience with the pediatrician providing behavioral health care, what role they see their pediatrician as playing in regards to the child's behavioral health, the clinical encounter that resulted in a referral, and the parent's reaction to these interventions. These interviews were analyzed using grounded theory methods by three independent coders. Through the analysis, themes emerged, out of which a code book was developed. Consensus regarding the themes was obtained through group discussion.

An interesting theme entitled "truth discovery" emerged from the interviews, in which a number of families were reporting changes in the family dynamics and family structure through one clinical encounter with the pediatrician. In this report, we illustrate this process, which we are calling "family truth discovery," by describing in some detail two parents' accounts of the clinical encounter with the pediatrician. The pediatrician's interaction with the child and family members was instrumental in revealed some truth in the family that was not known previously, altering the family dynamics that had been playing a role in the child's behavioral health symptoms.

Case description

Case 1: "Robert"

Robert was a 17- year old male brought to his primary care provider (PCP) by his mother for complaints of a "headache." The mother's expectation for the visit was to rule out a serious medical condition—"like an aneurysm." During the patient interview, Robert disclosed that he was upset about the presence of his mother's boyfriend. After the visit, the mother reports that Robert told the boyfriend that he does not feel he [the boyfriend] treats his mother well because he "always seems to be yelling at her." The mother reports, "Robert felt encouraged to talk to [the boyfriend] after the PCP visit and that "maybe talking [to the PCP]" gave him that courage. During the conversation with the mother's male friend, his mother recalls, Robert reveals that he "was wanting to kill him and things like that." The mother reports that as a result of this interaction with the PCP, "[the boyfriend] hasn't visited...since we've been to [the clinic], he has not been back at all." In summary, Robert comes in complaining of a headache and then uses the PCP visit as a venue in which to express his psychosocial concerns. He feels empowered after talking with the PCP and directly confronts the cause of his concerns as a result of the visit.

Case 2: "Janine"

Janine was a 13 year-old female brought to her PCP by her mother for an annual check-up. The mother reported that she had not planned to address behavioral concerns during the visit. The PCP, however, asks to privately interview the child. After talking with the daughter, the PCP disclosed the conversation to the mother, saying that the daughter was "dealing with peer pressure and anger issues." After talking privately with the PCP, the

daughter then reveals in the mother's presence that she had been "wanting to kill herself 6 months ago," as a result of self blame for her father's recent fatal car accident. The mother reports that this information was "hard to hear" and "came as a surprise to her," but that she was "happy she [her daughter] was willing to tell the truth to the doctor...I thought it was great news." The pair had "been having a lot of problems for over a year;" consequently the mother expresses gratitude for the daughter's ability to tell the doctor, "in confidence, " about what was bothering her. The mother leaves the visit viewing her daughter's moods and behaviors differently. Instead of seeing her daughter as rebellious and angry, she is surprised to learn that her daughter had been blaming herself for her father's death. While ongoing work is required for this family, the PCP visit helped to reframe the daughter's behaviors for the mother.

Discussion

Several potential clinical implications are elucidated by these cases. First, there may be more "family therapy" and behavioral health "treatment" occurring in their offices than pediatricians and pediatric trainees realize. This type of clinical interaction does not fit into a clear school of family therapy, nor does pediatric training take the place of training in family therapy. Nevertheless, there is change occurring within the family as a result of a clinical interaction. This goes beyond screening or identification of mental health disorders. A number of researchers have pointed out that behavioral health treatment can be effective without specifically targeting a particular diagnosis. The "common factors" concept, for example, describes a set of skills that pediatricians can utilize to address mental health issues, even when diagnostic specificity has not yet been achieved.⁶ A number of interventions to improve provider communication have been developed.⁷ The role that pediatricians can play in influencing family dynamics has also been elaborated in the family-focused pediatrics literature.⁸

While both of these children and families had ongoing behavioral health issues to be sure, a small "piece" of the behavioral health problem was addressed in the visit; behavioral health treatment may feel more approachable if providers recognize that these challenges can be addressed in bite-size pieces. Greater attention to helping pediatric trainees learn to conceptualize psychosocial and behavioral health problems in doable "parts" may help pediatricians readily approach behavioral health concerns. Researchers have identified solution-focused psychotherapy as a potentially useful format for pediatricians to engage in psychotherapy.⁹

The pediatrician's long-term relationship with the family and credibility as health authority has the potential to allow him or her to help families uncover the circumstances underlying emotional and behavioral troubles. It is not clear from these cases if the simple act of asking the questions and providing a forum for families to respond was what resulted in positive change, or if the clinician had particular qualities that enabled this interaction to occur. Whether this "truth discovery" can occur in any pediatric office requires further investigation; nevertheless, the study further supports the notion that pediatricians have an advantage in regards to providing behavioral health care for children and families.

Finally, these clinical encounters occurred in the context of a referral to specialty mental health. Robert did not follow through with the mental health evaluation, while Janine did. Did Robert's mother feel that the interaction helped "just enough" to not follow through with the referral? Did Janine's interaction with the PCP help the mother see the gravity of her child's concerns? While there are many factors that influence whether a family follows through with a referral³, these cases, highlight an important area for future research: How does the process of a pediatric referral to specialty mental health care influence whether a family will follow through with that referral? The process of the referral "readiness" and the specific role that the pediatrician has in the outcome of the referral is an area in need of further exploration.

The process of "family truth discovery" further underscores the "pediatric advantage" to provide behavioral health care for children and families, and elucidates the fact that small pieces of the psychosocial issues can be addressed in single clinical encounters. Ongoing research is also required to better understand the process by which pediatricians refer their patients for specialty care, the influence this process may have on subsequent follow up with mental health care.

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