

BECOMING A CLINICAL LEADER May 2, 2015

My name is Howard King.

I want to describe how with other professionals, we developed an alternative approach to integrating mental health concepts with pediatric care. Trust on the part of parents increased our self-awareness and helped us listen more thoughtfully to their multi-generational stories.

How did Children's Emotional Health Link come to be?

I received a one-year NIMH fellowship before starting practice to familiarize myself with issues of emotional behavior in children, learning how to listen and overcome blocks that once limited my ability to do so.

My second training experience came upon receiving an MPH after starting practice. I learned that a child with a problem could be an agent for change for the family. By compelling parents to bring the child to our attention, the child initiated a process of change important for the family. Parents became our colleagues and with increasing trust, were able to address issues not only with their children but also with themselves.

The last educational experience occurred while attending a yearlong seminar at a school of social work on the diagnosis of alcoholism. As the only physician present, why did I take this course?

I discovered that whenever there was a problem in the child, there coexisted a family secret. These secrets often accounted for how the child became the "identified patient" in the family. Sometimes it was a familial history of alcoholism. That impact of that secret was passed on through generations.

That course was a turning point in my understanding how family secrets could have a powerful effect upon children and parents. Many families are influenced by such secrets, which they may share if they trust us sufficiently.

Let me relate how a near tragedy in my family helped me become a better listener. Upon returning from military service, my wife became pregnant for the second time but, in doing so, developed a pregnancy-related problem.

NIH was studying the use of a drug to see if such problems could be diminished to preserve her uterus. She remained at the NIH for several months. Before long, she gave birth to our second son.

How did this affect me? I began “losing things,” right and left – keys, important papers, etc. A friend suggested I consider therapy which evolved into psychoanalysis.

I became aware that my losing things, i.e. mostly fearing that I might “lose” my wife recapitulated the fear of losing my father, who had been dreadfully ill when I was five years old.

His illness had a profound impact upon me and my family. I had repressed my feelings about that experience until my wife’s condition and my fear of losing her reawakened those memories.

Analysis also helped me become familiar with the process of “associations,” i.e. many statements parents express to us as physicians have hidden meaning. We may be unaware of those connections. But being attentive to a parent’s history may disclose what they are. If parents elaborate upon them, we may discover important insights.

Many of us discover the usefulness of associations in taking a routine history. Two things are a prerequisite for doing so – one is a willingness to provide parents with sufficient time to tell their story. The second is a genuine curiosity for the human condition and a respect for parents’ role as storytellers.

Later I became a health plan director and earned their trust. They allowed me to invite parents back for an hour long visit and be reimbursed.

As the same time, BCBS asked me to organize the annual AAP meeting to help pediatricians increase their competence in the diagnosis of childhood depression.

Because I helped organize that meeting, BCBS granted us the opportunity to be reimbursed for an hour long visit, making such a psychosocial assessment.

During this time I became familiar with screening for intimate partner abuse. With the support of BC, we distributed a guide to Massachusetts physicians. We downloaded the guide to a web site, gradually adding more information over time.

Funders encouraged us to organize a yearlong training program for pediatricians so they could become competent in the psychosocial assessment of children and parents.

We have succeeded with such training, documenting that with many evaluations. In the years this program has been offered, most participants have found it very useful; some have found it transforming. At each monthly meeting, we invite an expert to discuss topics related to psychosocial pediatrics including empathic interviewing skills; understanding family systems; the initial management of childhood depression; and other issues related to building a comprehensive skill base.

In an effort to utilize these skills, each participant presented a case from their practice. In preparation they received clinical supervision from course leaders. Participants discussed these cases and considered ways to help parents address the issues that arose.

When parents express worry that their child may have a psychosocial problem, or when we identify such problems, we encourage course participants to invite parents to return for a fifty-minute interview.

As a result, we anticipate participants will understand how the child's problem came to be and how to develop a plan for management and support. The name of the program is "CEHL" or Children's Emotional Health Link.

There are benefits which pediatricians achieve by asking parents to return when a problem is identified. What did our participants learn from our course?

- Pediatricians won't pick up the emotional problems of children without the help of parents.
- We can help parents learn how better decision-makers become.
- We advocate inviting parents to return for 50 minute visits when it is timely to do so. But the real task is to generate trust in our routine fifteen minute visits so parents will be motivated to return for longer.
- There should be parity between the physical needs of children and their mental health needs.

- Trust is crucial. Parents need it to share their stories and family secrets. We need to know how to nurture trust but can we also trust our peers with our *own* histories which may get in the way of listening to our patients?
- Who is the real patient? Parents believe it is the child. But it often turns out to be another family member. A family history may disclose that parents were adversely impacted by depression, alcoholism or abuse in *their* parents.
- What is the greatest impediment to having parents trust us with their stories? The key word is “stigma,” i.e. parents are often ashamed of what transpired with them. We need to acknowledge the importance of this task.
- We may overlook that the well child visit can be a corrective experience if we listen with a third ear, if we spend sufficient time attending the cues that parents share without realizing it, and convey dignity by listening respectfully.
- We did well when participants met monthly, taking turns sharing cases from their practices.

In conclusion, what do I hope you will take from this presentation?

- Our main objective is nurturing empowerment within the parents in our practice. If we do, parents can help make our work so much easier.
- The saddest statement is when I hear colleagues say, “I’d love to do what you do but I just can’t find the time.” But if they took advantage of this training, they could find time to do an assessment as good as most families require.
- Finally, even though our primary focus is on quality, parents can help us reduce health care costs. But we can also make pediatrics become a more satisfying experience for parents as well as for us, their physicians.

Let me conclude with three tips:

- I rarely use medications. For those who do, we have rewritten our psychopharm section each time we have done our program.
- Parents need time to tell their story. In my entire practice, my well child visits have been 25 minutes long.
- Finally, before we accept participants for our course, we meet each one and invite them to share their story.

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