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As a Pediatrician, I Don't Know the Second, Third, or Fourth Thing to Do: A Qualitative Study of Pediatric Residents' Training and Experiences in Behavioral Health

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As a Pediatrician, I Don't Know the Second, Third, or Fourth Thing to Do: A Qualitative Study of Pediatric Residents' Training and Experiences in Behavioral Health

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Introduction

Given the increasing prevalence of mental/behavioral health problems in children (hereafter referred to as *behavioral health* or *behavioral health problems*), as well as the recognition that pediatricians serve a primary role in managing these concerns, adequate training of pediatric residents is essential in order to meet the future behavioral health care needs of the population (American Academy of Pediatrics, 2009; McMillan, Land, & Leslie, 2017). In 1997, the Accreditation Council for Graduate Medical Education (ACGME) mandated a 1-month rotation in developmental-behavioral pediatrics (DBP). Although initially established to improve the behavioral health training in residency programs, there are concerns regarding the mandate's fulfillment of effective training opportunities and its relation to competent behavioral health practices as a pediatrician (Shahidullah et al., 2018).

Notably, pediatric residents overwhelmingly report suboptimal training in behavioral health care during their residencies (Rosenberg, Kamin, Glocken, & Jones, 2011; Hampton, Richardson, Bostwick, Ward, & Green, 2015). Less than half of recent graduates rate their competency in behavioral health care skills as very good or excellent (Horwitz et al., 2010). Further, a survey of DBP graduates reports similar comfort levels in managing developmental/behavioral health problems to those who did not receive the DBP mandate (Boreman, Thomasgard, Fernandez, & Coury, 2007), suggesting little added benefit in this area.

What contributes to perceived inadequate training? There is evidence to suggest that a substantial minority of residents do not obtain a full 4 weeks of training, with shorter duration impacting future practice (Stein et al., 2017). Another problem is the mandate, while specifying general core requirements and associated outcomes, does not indicate the manner in which training should occur (ACGME, 2017). With no specific curriculum or ideal method of instruction, there are large variations in the quality and content of relevant training experiences. Consequently, curriculum development and associated assessment of outcomes are necessary to improve current training experiences and by extension, the behavioral health competencies of future pediatricians.

The first step in curriculum development may be to obtain information from the learner regarding their experience. For example, Hampton and colleagues (2015) completed focus groups with pediatric residents to obtain feedback on problematic areas in behavioral health training and perceived barriers to care. Several themes – including capabilities, education, and organizational problems – suggest particular areas of intervention within residency programs. Qualitative approaches allow for the exploration of key themes and may add to the richness of quantitative survey data that has previously established a problem with current training approaches.

Statement of the problem

Despite a mandated 1-month rotation in DBP and several calls to action by leaders in the field, pediatric residents continue to report inadequate training in behavioral health care. As the first step in much needed curriculum development, and as an extension of published survey data on training experiences, this study sought to assess learner experiences regarding behavioral health

problems and training through the use of structured focus groups. The primary goal was to obtain specific information on attitudes, concerns, and beliefs regarding behavioral health care in order to influence future training experiences.

Method

The study was approved by the Institutional Review Board of Geisinger Medical Center.

Settings and participants

The sites of the residency programs were the flagship teaching hospitals of two large health systems in the same region of a northeastern state. Site 1 serves a largely rural catchment area and Site 2 serves a largely urban catchment. However, based on 2015 U.S. Census Bureau statistics (www.census.gov), the two sites are generally comparable in other relevant demographic categories including Caucasian-status population (Site 1; 94.1 vs. Site 2; 84.2%); high school graduation rates (89.4 vs. 87.4%); disabled-status under age 65 (89.4 vs. 87.4%); persons without health insurance under age 65 (7.8 vs. 11.4%); median household income ($54,648 vs. $56,117); and poverty rate (11.2 vs. 12.8%). Behavioral health training at both sites consists of an ACGME mandated 1-month rotation in developmental-behavioral pediatrics (DBP) in which residents shadow and observe hospital-based and outpatient behavioral health providers in psychiatry, psychology, and social work. Fourteen out of 36 residents at Site 1 participated in focus groups (6 out of 12 first-year residents, 8 out of 24 upper-level residents). Fourteen out of a 30 residents at Site 2 participated in focus groups (6 out of 10 first-year residents; 8 out of 20 upper-level residents). Background/demographic information was not collected on these specific participants who attended the focus groups.

The data presented in this paper are a part of a larger research training project aiming to improve the behavioral health and communication skills of medical trainees. All residents included in this study provided informed consent for participation.

Data collection and analysis

Study investigators enrolled a convenience sample of pediatric residents to participate in focus groups to describe attitudes, concerns, beliefs, and barriers in their training and experience in managing behavioral concerns with pediatric patients and their families. The use of focus groups was chosen to generate information regarding perceptions of training and experience in behavioral health that would go beyond the information that could be gathered using quantitative surveys and one-on-one interviews. Residents were recruited by residency staff (i.e., pediatric residency program director, chief resident, and secretarial personnel) for their voluntary participation. Food was offered as an incentive to participate. Participation for the focus groups occurred on a “first come, first serve” basis with the target size of the groups being 6-8 residents each. Four separate focus groups were held (2 at each training site). Focus groups were conducted in July 2015 and lasted 60 minutes each. Focus groups included residents from all three residency years across both sites. First-year residents’ focus groups were conducted alone at their respective sites, while upper-level residents were conducted together. The data were coded and analyzed together.

A trained researcher who was unknown to the residents moderated the focus group discussion using a semi-structured interview guide that used open-ended questions to elicit participant's perceptions. The interview guide was developed by study investigators. All opinions/responses were spontaneous and individual participants were never directly called on to provide a response. A research assistant audio-recorded, took notes, and later transcribed the conversation. A second research assistant wrote down a summary of responses and themes on large butcher paper and posted those on a board throughout the focus group where they were visible to residents as a reminder of key points already discussed. As focus groups were conducted, the moderator periodically summarized participants' answers and confirmed that responses received up until that point were accurate. Data (transcripts) were analyzed manually.

Six study investigators initially reviewed the transcripts to identify key themes using qualitative classical content analysis (Leech & Onquegbuzie, 2008). These study investigators individually coded each transcript before reconvening as a group and establishing concordance on the coding of each response to a theme using an inductive approach. Statements were divided into units including phrases, sentences, or paragraphs that depicted a given theme. It was determined that saturation was met after these four focus groups (reported information began to repeatedly occur and the additional collection of more data did not appear to provide additional worth).

Results

The focus group analysis revealed nine key themes related to residents' attitudes, concerns, and beliefs regarding pediatric behavioral health care and training. These themes emerged universally across both sites and in comments made by residents in all 3 years and included the following: *time requirements, rapport building, resources and referrals for behavioral health, psychiatric medications, diagnosis vs. treatment, working with families, the importance of behavioral health, fears of working with a pediatric population,* and *training issues.* These themes are expanded upon below.

Time requirements

Residents reported concerns related to the shortage of time allotted to adequately assess and treat children and families with behavioral health concerns within office visits. They noted the difficulty in balancing rapport building and addressing the patient's or family's need to talk about their concerns while attempting to stay within their appointment time. As one resident explained, "Fifteen minutes for an ADHD kid or a depression kid or parents wanting to talk about their issues with their kid is definitely not enough time." Similarly, another resident asked: "How do I develop any kind of relationship with this patient that I am meeting for the first time in a 30-minute time slot? By the time they are finally opening up, it is time to go…".

Residents also expressed frustration with encountering an unexpected behavioral health problem during an office visit, with little or no time to address it:

> …then you come in and they are like, "Oh, you know this is a developmentally delayed child and we have had all these sexually inappropriate videos on their iPad. What do we

> do about it?" and I'm like, "I don't know, I thought you were going to say they had a fever or she wasn't eating." I was expecting something different.

For residents who may have very little training or comfort in addressing behavioral health needs, attempting to juggle rapport building, accurate assessment, and the provision of appropriate treatment in a fast-paced primary care setting is difficult. This is particularly problematic when behavioral health concerns are brought up unexpectedly during an office visit or when the primary behavioral health problem is masked as an unrelated physical health issue (e.g., stomach pains vs. anxiety).

Rapport building

Residents are aware of the importance of building rapport and trust with their patients and noted the difficulty of doing so in the context of a behavioral health visit. Several residents brought up the specific difficulty of rapport building with teenagers. One resident expressed frustration when "… it's a teenager and the patient is in the room with the parent and you tell them 'you have to listen to your mom and dad' and they roll their eyes at you…". Residents also noted that teenage patients can be guarded about their problems – particularly depression or drug use – which the residents identify as a weakness in their rapport building and a barrier to providing care. One resident noted that they believe "teenagers feel more comfortable answering questions on a computer than having a face-to-face conversation."

Related to rapport building is the establishment of the patient's or family's trust. A resident remarked on the difficulty of making a mistake as a trainee: "one slip up and they lose trust in you forever." Regarding trust that a family has with a provider across time, one resident noted, "you can't pick that up the first time you meet them."

These concerns may be related to a lack of training or competence in communication skills that strengthen alliance and allow the patient to feel heard, also known as "common (non-specific) factors" (and which often relate to positive behavioral health outcomes). For instance, targeting motivational interviewing skills in residents (which few noted that they had training in) may help residents learn how to build trust and relationships with their patients.

Resources and referrals for behavioral health

Another concern reported by residents was lack of knowledge of community and system resources available for children and families with behavioral health concerns. One resident reported problems with "coming into a new system and not knowing what resources are available and where to go." Similarly, another resident stated, "…our biggest issues are that we have problems with our kids that are more complex…and need more specific help." Residents brought up the need for children to see behavioral health specialists, noting the shortage of these providers (e.g., child and adolescent psychiatrists, psychologists, clinical social workers).

Several residents also noted the lack of available resources in their clinics on basic information on behavioral health problems. For instance, one resident stated, "I can google ADHD and a million things come up but what's the best resource to actually look at?". Many also noted that

their attending/precepting physicians did not always have the training or competency to help them, while others brought up the lack of time to be able to do the research on their own.

Psychiatric medications

A recurring concern for residents pertained to their role in prescribing psychiatric medications to a pediatric population, often with very little training, guidance, or oversight. Notably, one resident stated: "Every medication I prescribe, every step of every day you take back and you are like, 'Did I do that right? Am I doing the right thing?''. Residents reported worries related to the type of medications prescribed, dosage, when to start medication, and whether medication is clinically indicated for the presenting problem. For some residents this was particularly concerning given the safety risks with children. As one resident shared: "…it's a different world for kids, getting dosing and getting them put on medication is a whole new experience for me…". Overwhelmingly, residents questioned their decisions with prescribing medications and were worried about their ability to safely and effectively provide this treatment for children.

Diagnosis vs. treatment

Residents reported relative comfort in diagnosing behavioral health disorders, but alluded to discomfort in treating them. These concerns range from providing psychoeducation on developmentally normative problems (childhood tantrums or toilet training) to managing more severe conditions (e.g., autism spectrum disorder, psychiatric disorders). Treatment, therefore, is not solely prescribing psychiatric medication, but providing behavioral tips or managing outpatient psychotherapy. As one resident remarked:

> As a general pediatrician going back to the original behavioral component of stuff, I don't know the second, third, or fourth thing you are supposed to do for kids in a timely manner. I don't know the next thing to do if you have trouble sleeping. I know one or two things you could try but after that I don't, so I would refer to someone else.

Similarly, one resident stated: "When you feel like they have had all the treatment that you know to give them, but they are still having suicidal ideas, like what do you do with them now?".

Working with families

Of particular relevance to residents working in pediatrics is how to effectively work within the context of a family system. Residents acknowledged that they were often treating the family as opposed to the individual child and that communicating effectively with parents was essential for good care. As with most behavioral health concerns, parents are considered an important part of assessment, treatment, and patient education. Finding ways to navigate the family dynamics and differing perspectives on treatment was reported as challenging to residents. As one resident reported:

> In the peds world, I have experiences where I might be able to deal with a child, but the parent has backlash and that was the part where I had no idea what to do. I got that they were blaming me, but I had no idea how to get back on their team.

Another resident noted: "It can be difficult, especially when you have a parent who you are trying to encourage to do something…and you can tell that you are not really getting through to them."

Importance of behavioral health

Residents acknowledged the importance of addressing behavioral health needs despite a potential bias to emphasize physical health conditions. For example, one resident stated that their "knowledge of most psychiatric disease is very much lacking", but that they were "glad that you guys [psychology] are here [in a primary care setting]." This resident went on to note that given "how much importance falls on pediatricians [to provide behavioral health care] …I probably have a long way to go."

Fears of working with a pediatric population

Residents also reported specific fears related to treating children, particularly missing a problem/diagnosis or making a mistake that is potentially life threatening or could affect the child's health longitudinally. One resident reported, "I feel a huge amount of pressure being at the front lines not to miss big things." Many of the residents' worries appeared related to physical health, although some were indicative of behavioral health concerns as well. One resident expressed concern that he/she could miss child abuse: "you don't know what's going to happen or if it's going to scar that person's life."

Training issues

Residents overall expressed frustration that they are ill-prepared to provide behavioral health services to children. Prior to beginning residency, many reported only having experience in adult psychiatry (e.g., inpatient psychiatry working with patients with schizophrenia and other serious mental illness). Further, several noted that their training in medical school was mostly didactic and passive in nature. One resident stated, "My psych experience in med school was basically what the book taught you" while another stated that their experience "was definitely more lectures." An overall theme within training was the perceived lack of importance placed on behavioral health issues – rotations were generally specific (one setting and patient population), with little emphasis placed on experiential learning and the biopsychosocial model. This continued in residency, where their on-the-job experiences of navigating behavioral health issues were often described as inadequate.

Discussion

Despite the addition of the DBP mandate in 1997, pediatric residents continue to report inadequate training experiences in behavioral health. This study expanded previous survey research to more extensively examine residents' attitudes, concerns, beliefs, and barriers in their training and experience through the use of focus groups. Grounded theory analysis revealed several themes across residents and training sites that reflect their current experiences and suggest potential implications for curriculum development. These themes ranged from lack of

appropriate training experiences to learning to communicate effectively with families and children. Residents acknowledged that an emphasis on behavioral health is needed (*importance of behavioral health*), but remarked on several barriers to providing good behavioral health care: time constraints and other systematic problems, lack of knowledge (e.g., psychosocial treatment or psychiatric medications), and frustrations/concerns/fears related to working with families and children. This analysis supports and extends previous research on pediatric residency training gaps and weaknesses (Rosenberg et al., 2011; Hampton et al., 2015).

Residents' responses provide implications for training. For instance, the need for a greater focus on knowledge-based training in the treatment of childhood psychological disorders as well as developmentally normative problems such as sleep and toileting (*diagnosis vs. treatment, training issues*). Relatedly, didactic and experiential training in psychotropic medication management is a significant need for residents, who generally receive little training prior to residency and typically only with adult populations (*psychiatric medications).* Training in this area is particularly important given that pediatricians often prescribe psychiatric medications for children due to the shortage of child psychiatrists in this country (Kelleher, Hohmann, & Larson, 1989; Mark, Levit, & Buck, 2009).

Several themes (e.g., *rapport building, working with families, fear of working with a pediatric population*) suggest that residents will benefit from further training in communication skills. Alliance-building skills – i.e., the ability to be empathic, allowing patients to feel heard by using skills such as reflective listening and open-ended questions, working collaboratively, among other essential skills – have been associated with improved outcomes in psychotherapy (Baldwin, Wampold, & Imel, 2007; Horvath, Del Re, Fluckiger, & Symonds, 2011) and are just as important for improved health outcomes in the medical setting.

Lastly, residents' report of time management and lack of resources suggest that medical practices must consider systematic changes that will allow for better behavioral health care (*time requirements, resources/referrals for behavioral health).* Specifically, systems in place to allow for improved assessment/screening, a culture that places importance on behavioral health care (and time or resources available to handle behavioral health needs), and the ability to collaborate with behavioral health professionals, ideally within an integrated care setting.

In 2009, the American Academy of Pediatrics put forth a policy statement outlining competencies in behavioral health. Although the policy statement emphasized the need for improvements in current educational practices of both residents and current practitioners in the field, it did not endorse any specific training modalities or methods of doing so. Several within the field have suggested the context of integrated primary care as a potential learning opportunity (AAP, 2009; McMillan et al., 2017), in which behavioral professionals (e.g., licensed clinical social workers or psychologists) work side-by-side with medical residents as a team, providing care for all behavioral health concerns (Shahidullah, 2017). This method of care delivery is particularly apt to promote in-vivo training of residents using experiential and hands-on learning experiences in clinical settings they will be practicing in. It also fosters team-based care and decision-making, which is associated with improved outcomes with patients among many other benefits (Agency for Healthcare Research and Quality, 2016). Several studies have demonstrated that residents feel more comfortable and confident with addressing behavioral health concerns

when a behavioral health professional is on-site and also believe that they are providing improved quality of care while having the opportunity to collaborate with behavioral health clinicians (Gouge, Polaha, & Powers, 2014; Hemming, Hewitt, Gallo, Kessler, & Levine, 2017). Future research may determine how this model of care impacts the behavioral health training of residents and future clinical practice.

Limitations

There were several limitations to this study. First, although efforts were made to keep the coding process as objective and systematic as possible, there are possibilities that our data are not a completely accurate representation of what the focus groups consisted of. Our sample may also be limited by geographic or other demographic variables, which may restrict the generalizability of the findings. No additional survey measures were administered to the participants during the focus group process to determine other demographic or training backgrounds. Specifically, some of the participants may have already completed their required developmental-behavioral pediatrics rotation, while others may not have. We did not ask residents to report this information and, thus, have no way of knowing how this may have affected focus group responses. Given that the focus groups were comprised of residents who were motivated to attend, there may also be a self-selection bias.

Conclusion

These results provide further evidence for the compelling need to improve training of pediatric residents in managing behavioral health concerns. Continued efforts to find the most effective and feasible methods of education is necessary to best provide for the needs of children and families who continue to experience behavioral health problems at a growing rate and who go to their pediatric primary care provider for help. Integrated care settings show promise for improving the training of residents, while also enhancing collaboration between behavioral health and medical providers and improving the quality of care provided. This study served to identify gaps in training and areas of reported need that may inform future innovations in training curricula.

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