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"We've Tried Everything and Nothing Works": Family-Centered Pediatrics and Clinical Problem-Solving

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CHALLENGING CASE: FAMILY RELATIONSHIPS AND ISSUES

"We've Tried Everything and Nothing Works": Family-Centered Pediatrics and Clinical Problem-Solving*

CASE

Steven is a 9 year old who was brought to his pediatrician 1 year ago when his parents were concerned that "he never pays attention and is always forgetting to do his chores." Attention-deficit disorder (ADD) was diagnosed. Steven responded to a stimulant medication and behavior modification moderately well for several months. Then, the original problems reappeared, and, despite trials of different doses and different medications, things worsened. Although Steven's school performance was good, the teacher and parents felt his self-esteem was declining. This worried his parents, who were also experiencing increased disagreement and conflicts about managing "Steven's ADD." Furthermore, his younger brother was starting to "act up like Steven." Phone calls and visits became more frequent and urgent. The pediatrician suggested the family join the local CHADD (Children and Adults with ADD) support group and loaned the parents some books on ADD. He met individually with Steven (who did little talking) and with the mother (who ventilated her worries and frustrations). He even met with the family to review Steven's situation, offer reassurance, check on compliance (which was good), and to offer more advice concerning the growing number and complexity of the problems. Things continued to worsen, and, at the latest visit, everyone seemed discouraged, angry, and tired. Although the pediatrician felt he had run out of answers, he also felt that a referral (for either Steven or the family) was not appropriate at this time, that he was uncertain to whom he would refer, that the family would not accept a referral, and that his managed care practice would not approve a referral in the present situation.

Index terms: *family-focused pediatrics, patient-doctor communication, family therapy*.

Dr. Martin T. Stein

In most areas of medical practice, it is insufficient to be satisfied with an initial diagnosis and treatment plan. That the diagnosis or treatment is incorrect is an occasional occurrence. A more frequent development in clinical practice is that as new information surfaces, a new diagnosis is proposed or the treatment must be altered significantly. Monitoring patient progress has been a hallmark of clinical practice as a way to define new problems, check on compliance, and, if necessary, readjust management.

The case of Steven exemplifies this principle. Although specific information concerning diagnostic criteria for attention-deficit disorder (ADD) is not given, the case study illustrates the process of follow-up and monitoring by a pediatrician. Steven's problems with attention seemed to be situational; they seemed to affect organization, chores, and self-esteem more than classroom learning. To his credit, Steven's pediatrician discovered both significant differences in parenting styles that resulted in conflicts and behavioral problems with a sibling. The pediatrician's response involved a multimodal approach within the limits of an office practice. He referred the parents to a community resource, loaned books about ADD to the parents, and met with the parents and the entire family on different occasions.

The commentaries that follow were written by two clinicians who have directed their academic work toward the application of family systems theory within the practice of primary care medicine. This particular perspective was chosen to illustrate alternative pathways to the approach of patients such as Steven and his family. It is not the only option available to pediatricians, but, arguably, it is one that is poorly understood and underused among pediatric clinicians.

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General pediatricians and developmental-behavioral specialists are increasingly called on to help resolve a wide variety of behavioral-biopsychosocial problems of children and adolescents and their fam-

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ilies. As parents work longer and harder and have less time and energy for family time and as traditional family supports (nearby extended family, schools, community resources) are less available, parents are increasingly turning to pediatricians for advice and support.[1]

Pediatricians are trained in the biomedical model, which is usually effective for common, early-stage, mild, and predictable developmental, behavioral, and parenting problems. Examples include developmental variations and delays; developmental transitions in the child, adolescent, or family; temperament differences; parenting problems; and noncompliance. The traditional model is a patient-focused, problem-focused assessment with doctor-prescribed interventions; it usually requires caring, competent, and motivated parents.[2] These interventions might be classified as the five Rs:

1. Reassurance (emotional support);
2. Recipes (advice about the problem);
3. Readings (education, demystification);
4. Ritalin (and other various medications); and
5. Referral (consultation or collaboration with a pediatrician).

The targeted behaviors or stressors, however, might not resolve with this traditional model, as in the case of Steven's family. In addition, more complex problems often require an alternative approach. These might include recurrent pain syndromes, conflict and disagreement over different parenting styles, school refusal, parenting problems, the vulnerable child syndrome, and family relationship disturbances secondary to ADD. Several of these issues are represented in this case study. The patients and their families, as well as the pediatricians, need something else, another theoretical and clinical model, which I call *family-focused pediatrics*.

Family-focused pediatrics is a solution-building, family-systems approach that assumes a biopsychosocial perspective and mobilizes the strengths of families and of each individual. It uses pediatricians' experience and expertise, their knowledge and understanding of their patients, and their position of trust with families. This model does not assume a typical or ideal family and is applicable to families of all social, economic, racial, ethnic, or religious backgrounds. Family-focused pediatrics is an answer to "we've tried everything and nothing works" and is suitable for brief, office-based pediatric encounters.[3]

Solution building is an innovative way to interview patients (meaning the presenting patient and any other family member), a set of new skills that focuses both pediatrician and patients upon the patient's developing a goal and a more satisfying vision of themselves. These skills enable both pediatrician and patients to work together, to "co-construct" a heightened awareness of strengths and resources with which to create solutions to achieve the goal and to make the vision a reality. Pediatricians empower their patients by yielding as much control as the patients can handle. Physicians facilitate the process and lead by following, by taking their lead from their patients. This process looks forward, not backward, and fosters hope, because it motivates the patients to work hard within their own frame of reference. This approach gets the family and the pediatrician away from talking about the problem to talking about the solution.[4]

A family-systems perspective might be appreciated by envisioning a mobile as a metaphor of a family, with the various members arranged in a hierarchy and connected together in positions and arrangements that connote physical and emotional closeness.[5] The family is in constant dynamic motion but maintains its own structure, function, and sets of relationships. The movement of any one member affects all of the others, some more than others. Family members are both separate and a part of the whole, and all members play their separate roles while fulfilling their family roles in maintaining the family's balance.

Family-focused pediatrics is an approach that blends solution-building and a family systems perspective with aspects of the biomedical approach (but with minimal emphasis on "problem solving"). It is especially useful in pediatrics. For a better appreciation, however, of the unique aspects of the solution-building, family-systems approach, it is helpful to contrast it with the biomedical approach, which has the following characteristics:

- the patient is the sick one, the victim, the passive partner in the patient-doctor relationship;
- the patient has a problem, a dilemma;
- the doctor is the problem-solver with all the power and knowledge, the expert;
- the focus is on the child or adolescent and on the problem (which necessarily emphasizes deficits and psychopathology);
- the doctor takes a detailed history of the problem, performs a variety of examinations/screening tests, and orders other tests and procedures as indicated;
- the doctor treats, heals, solves the problem with a variety of interventions/referrals;
- the doctor does most of the work ("working up the case," dispensing directives, advice, prescriptions).

Contrast this with the solution-building, family-systems approach. Note that in this approach, "patients" will include the presenting patient and any other family members:

- the patients are not (sick) "patients" but instead are willing, equal, and active participants in a mutually respectful encounter;
- the patients have a problem, but, more importantly, they also have solutions;
- the patients and the doctor together are problem solvers, but, more importantly, they are solution builders; the patients are experts with their knowledge and power;
- the focus is on the patients and their family system and on their goals and solutions (which necessarily emphasizes strengths and competence);
- the doctor takes a brief history, if any, of the problem and uses that information as a spring-

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board to determine what the patients would like to experience instead of the problem; the doctor takes a detailed history of the goals and solutions by asking a variety of questions and listening carefully;
- the doctor and patients together develop solutions;
- the patients assume increasing initiative and responsibility and do most of the work.[6]

Family-focused pediatrics is not family therapy (usually a long-term, psychodynamic process) nor family counseling (usually the mental health professional giving advice concerning the problem). It also adheres to the notion that just because pediatricians discover a problem, they are not obligated to assume clinical responsibility for it. Where appropriate, they are expected to encourage and prepare the family to accept a referral.

The solution-building approach applied to Steven and his family illustrates the family-focused pediatric model:

- Problem definition allows a brief description of the problem (KISS: Keep It Short and Simple). "What brings you here today?" "What can I do to help?" The mother might answer, "We want to get some answers to Steven's problems, like not doing his chores and being a negative influence on his brother."
- Goal negotiation defines clear, realistic goals that tell patients and doctor the desired outcome of the meetings. "What would you like to see happen as a result of our meetings?" "What would you like to see happen instead of the problem?" In this case study, the family would discuss and negotiate one or two (related) goals that are realistic, observable, achievable, and meaningful to the family.
- Hypothetical solutions help the patients shift from dwelling on the problem (with attendant feelings of blame, anger, guilt, and helplessness) to their goal, their vision of something better. This is the start of co-constructing solutions. "Suppose, by some miracle, the problem that brought you here were solved. What would be different? What would be the first thing you would notice that would begin to tell you things were better?" In this case, members would share their "solutions" and the pediatrician again would help the family focus on one or two that relate to the goal.
- Exceptions (to the problem) uncover and elaborate those times when the patients are doing something right and workable, and different enough from the problem so that the problem is not occurring or not noticed. Exceptions are real-life demonstrations of solutions. "When was the last time that even a little bit of that miracle was happening?"(e.g., being a good influence on his brother); "What were you doing instead of _______?" (e.g., "not doing chores"). In this case, the pediatrician encourages family members to describe their behavior in specific terms.
- Family systems apply the family mobile principles. "When you were______ (doing something right), what did you notice about your mother?" "What was she doing?" "What do you think she was feeling?" "How did you feel when you saw _______ (desired behavior or positive affect)?" "How could you tell?" "What would you (mother) be doing when your daughter (son, husband) is more ______ (polite, attentive, happy)?" In this case, the pediatrician encourages family members to describe others' behaviors and feelings as well as their own responses to another's desirable behavior or feelings. This allows family members to see how they are all connected and do influence each other.

The pediatrician in this case scheduled three visits. The first, with the whole family, was 30 minutes long. The second (just the parents) and third (the whole family) were each 20 minutes long. The interval between visits was 4 weeks. With the use of the questions noted above and by allowing the family to do most of the talking, it was revealed that the family's goal was "to get along better." It turned out that Steven did "pay attention"at school and did do school-related "chores" and felt resentful that his mother only focused on the home situation and did not praise him for school. Dad pointed out that Steven was attentive and responsible when they did household repairs together. Steven was saddened by the focus on his ADD, medications, and doctor visits. He felt that he was "not a good son." His brother was "acting up" because he wanted to get more attention and trips to the doctor, which included a stop at the ice cream parlor. The mother had heard that "boys with ADD were high risk for juvenile delinquency" and interpreted Steven's "acting up" as the first step. The mother was operating under a misconception about ADD, was tense, worried, trying too hard, and doing too much. She was very worried and felt unsupported by her husband. Despite the fact that she felt "like the heavy" in the family, she felt that she had to be very firm. Finally, the parents stated that they had "not been on a date for 6 months."

It was apparent to all that Steven had many unacknowledged islands of competence (exceptions) and some unexpressed emotional needs. The father spent more time with both boys but saved some special time just for Steven. The mother had more time for herself. The parents arranged to go out twice a month. Steven's medication was used only for long homework assignments and test preparation. By the age of 14, he no longer needed his medication. He was doing well in school and regularly earned his allowance by doing extra jobs at home and in the neighborhood.

It was apparent that Steven's ADD was very situational (sustained periods of independent studying and time management, e.g., getting chores done). The increased inattention and forgetfulness at home and the low self-esteem were secondary to the family's overfocusing on Steven's ADD, his subsequent feelings of being the scapegoat and the problem child, the mother's anxiety about juvenile delinquency, and the parents' disagreement about managing Steven's ADD.

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Dr. Ronald M. Epstein

Effective involvement of the family in clinical care gives the physician an opportunity to gather information unavailable from the index patient, to observe family dynamics, and to involve the family actively in a treatment plan.[1] In the case of Steven and his family, the physician demonstrated identifying the need to expand the view of the problem, convening relevant members of the family, getting additional contextual information, and maintaining a therapeutic alliance with several family members simultaneously. The rules of discourse were changed from problem-focused to solution-focused, allowing the family to arrive at and execute a therapeutic plan. They reframed the problem from "Steven's ADD" to "getting along better as a family." The physician used a psychoeducational approach that corrected parental misinformation. At the same time, the physician gave them tools to solve problems as a family. This was the right intervention at the right time for the right family.

Understanding contextual factors can be as important as understanding the biomedical aspects of illness. For most patients, the family is the most relevant social context.[2] The "simple" nuclear family, however, (married heterosexual couples with children) currently accounts for only 25% of households. Commonly, the "family" is more complex, consisting of a variety of biologically related and unrelated people who are important in the patient's life. Consider the recently encountered situation of an adopted child who lives with a paternal great-grandmother for 4 days each week while his mother works the night shift; he spends occasional weekends with his father in a nearby town; and he eats dinner nightly with a maternal aunt. It was a challenge to gather sufficient information about the family to assess who would be the most relevant people to invite to a family meeting to discuss the child's behavioral problems at school.

Timing is important. Steven's family had significant prior contact with the physician. Trust had been developed, and the family and the physician were in agreement concerning the nature of the problem. Simple, "first-order"[3] solutions such as medications, advice, and education had been tried, with only partial success. Adherence was not the problem. The family was ready and willing, making this an opportune time to expand the inquiry by inviting relevant family members.

"Second-order change"[3] refers to the process of redefining the rules of discourse and reframing the nature of the problem.[4] Clues to the existence of "second-order problems" are lack of response to simple first-order attempts to resolve the problem, resistance on the part of the patient or a family member, ineffective communication with the patient, and unhelpful family communication patterns. Physicians commonly employ second-order change strategies when they ask patients to become active participants in their care. Rather than suggesting another solution to a patient, second-order strategies might include taking a new approach to the *process* of problem-solving, including discussion with the patient and the family about how it has been for them to try to solve the problem. Reframing individual problems as family problems can be effective if it is done in a way that does not blame individuals or the family as a whole.

In a medical culture dominated by the separation of mind and body, inviting the family to participate might be construed as abandoning biomedical interventions.[5] Rather, the opposite is true; the expanded focus includes the biology as well as the psychology of illness. In this case, the diagnosis of a psychobiological disorder, ADD, was useful, and medications, rather than being a cure, became part of an expanded approach to care. With use of this expanded view of clinical care, the clinician must always remain alert to treatable symptoms, regardless of whether they are physical, psychological, or social. Families often have valuable perspectives on patients' responses to medication regimens as well as barriers to adherence to treatment plans.

There were two transitions exemplified in this case: from diagnosis-centered care to patient-centered care and from patient-centered care to family-centered care. The transition from a focus on diagnosis to a focus on the patient involves taking into account the patient's experience of illness and the patient-physician relationship. The transition from patient-centered care to family-centered care involves expanding the clinician's view of who is the "patient" and then recasting clinical skills. Just as rapport and empathy facilitate self-disclosure and trust with individual patients, developing rapport by "joining" the family and demonstrating understanding of each family member's perspective on a problem can facilitate collaborative problem-solving. By adopting an attitude of active curiosity in learning each member's point of view, the clinician can convey a genuine interest in the family. The clinician might need to intervene or interrupt to make sure all perspectives have been heard and to make it clear that the physician's job is to facilitate change, not to take sides.

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Confidentiality is important, especially when several or all family members are under one physician's care. The physician should be explicit as to what information will and will not be kept confidential. It might take several sessions, and sometimes months, to gain the trust of all of the family members, so that they will be able to collaborate on a therapeutic plan. Family members often fear being blamed for the patient's failure to improve. Even if the physician sees unhelpful contributions from family members, explicit identification of helpful behaviors is important, even if it is just having come to a meeting. Family conflict is inevitable. The physician should reiterate all points of view without taking sides and should actively maintain focus on the solution to the problem at hand.

Many families are receptive to becoming more involved in health care. Initially, however, some families may be overwhelmed, and the physician might need to garner more social supports for the family members before they are ready to take greater responsibility. It is sometimes necessary to state explicitly that an increase in the family's responsibility does not mean that the physician has abandoned the task or the patient; autonomy should not preclude interdependence.

Family physicians and pediatricians often take care of several members of each family in their practice. Some regard the family rather than the individual as the unit of care and use family medical records rather than individual ones. For all practitioners, however, the family is always present psychologically and in spirit, even if they are not physically present.[6] Thus, "family-oriented primary care"[7] can be practiced with individuals and apply to all aspects of care.

Caring for patients can generate strong feelings in physicians. These feelings can have a powerful effect on the patient-physician relationship and on clinical care. Similarly, some family constellations and dynamics might recapitulate experiences in physicians' own families, or, conversely, might be so different that it is difficult for the physician to develop empathy. Physicians' self-awareness of their own emotional reactions to patients and families can help them to accommodate to their "blind spots" and also to recognize and to use their particular areas of strength. Family medicine training programs often involve seminars that focus on self-awareness. One particularly useful format uses genograms (family trees) to explore the impact of the history, values, and traditions of one's family-of-origin on patient care.[8] Physicians caring for families would be well advised to learn more about their own.

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Dr. Martin T. Stein

The case of Steven and his family might have been subtitled, "Beyond Conventional Pediatric Therapy." A family history in most pediatric medical records is limited to genetic disorders, household members, and parents' occupations (and possibly education levels). As pediatricians, we are often unaware of family conflicts (including marital discord), depression, or other emotional disorders in parents or of important historical information concerning the childhood experience of our patients' parents. Relationship conflicts among members of a family usually surface only when they are part of a presenting problem. Traditional pediatric practice recognizes Dr. Epstein's observation that "For most patients, the family is the most relevant social context." Primary care pediatricians, however, have not developed an acceptable way to incorporate that observation into their diagnostic process or therapeutic plans.

Dr. Coleman's comparison of traditional practice ("biomedical") with a solution-building/family systems model is a good start toward shifting the emphasis from the patient (child or adolescent) to the family in selected cases. Table 1 summarizes his

TABLE 1. Comparison of Biomedical and Solution-Building/Family System Approaches to Patients

	Biomedical	Solution-Building Family Systems
Patient role	"Sick" patient; passive partner	Equal and active participants
Patient focus	Problems/dilemmas	Solutions
Expert	Physician	Physician and patient/family as problem-solvers and solution-builders
Encounter focus	Deficits/pathology of individual; extended history of the problem	Strengths/competence of family system; brief history of the problem; detailed history of goals and solutions
Therapeutic focus	Physician's decisions	Physician and patient/family develop solutions

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ideas. The major contribution of this model is that it offers the pediatrician a user-friendly way to adapt a family systems approach to pediatric practice. By focusing on the development of solutions to a set of adverse behaviors and by encouraging the expanded patient (i.e., the child or adolescent and other family members) to develop those solutions, Dr. Coleman has formulated a new set of clinical challenges. His emphasis on the recognition and therapeutic use of discovered strengths in the patient and family is rooted in pediatrics.[1] In Dr. Coleman's model, the physician and patient/ family join together to discover alternative choices (solutions) that build on strengths. Once a problem is defined, precious, limited time with the patient is used to assist in the formulating of solutions. The solution-building, focused questions asked of Steven and his family are a useful model for clinicians in the process of learning this approach.

Dr. Epstein describes some of the components of family participation in the clinical care of patients. The diagnostic and therapeutic value to the physician in observing family dynamics and involving the family in a treatment plan seem obvious. Primary care pediatricians would be quick to respond that time limitations in the office or clinic make this strategy inefficient for most patients. Dr. Epstein suggests that the process of "redefining the rules of discourse and reframing the nature of the problem" can be limited to those patients with specific characteristics, i.e., a poor response to treatment, resistance to therapeutic recommendations, ineffective communication with the patient/parent, and unhelpful family communication patterns.

This approach should be attractive to pediatricians. The principles of reframing a problem are known to pediatric clinicians in the context of existing medical practice for organic disease. For example, although most children with asthma responded rapidly to inhaled bronchodilator medication used episodically, asthmatic patients with frequent symptoms that affect social, physical, and cognitive performance require "a reframing of the nature of the problem." This new strategy usually goes beyond the prescription of additional medications (e.g., maintenance therapy with an inhaled anti-inflammatory medication); it requires a heightened level of communication with the patient and the family to insure knowledge concerning asthma, to accept and maintain environmental changes in the home, to learn how to monitor symptoms and adjust medication, and to begin an exploration of psychosocial factors that contribute to poor asthma control. To achieve these goals often requires a joint effort among physician, patient, and parents.[2] Improved compliance and less resistance to treatment is more likely when the physician has attended to parent and child perceptions concerning asthma, family conflicts that could interfere with compliance, and the quality of trust within the patient/family-physician relationship.

Both a solution-building strategy and family-centered care have been incorporated into the management of children with complicated asthma. Most allergists and pediatricians, although already making use of some of the principles outlined by Drs. Coleman and Epstein, would benefit from additional knowledge and training. Primary care pediatricians could make use of these concepts in the management of a wide variety of patients with other common problems—with organic illnesses (e.g., recurrent otitis media, chronic allergic rhinitis, and migraine headaches) and with behavioral problems (e.g., severe temper tantrums, delayed toilet training, school refusal, and high-risk adolescent behaviors).

Change in clinical practice patterns is slow and tedious among physicians in practice for several years. Medical students, residents, and fellows, however, should be open to the models described in the above commentaries. The prenatal visit[3] offers an early opportunity to make use of some of these concepts. An emphasis on the parents' childhood experiences, what they learned about raising children, and an exploration of their expectations for the new child sets the tone for a family-centered approach. At the same visit, the idea of a therapeutic alliance[4] can be framed in terms of working together to prevent and manage many aspects of their child's growth and development.

Dr. Epstein's final statement deserves special attention. Physicians (other than those who have completed psychiatric training or fellowship-level behavioral training) generally do not take into account strong, personal feelings that are generated during the process of patient care. Anger, sadness, ambivalence, anxiety, and confusion could be the result of unrecognized life experiences similar to those being experienced by their patients. Although these feelings could surface in pediatric practice when working with a child and parent alone, they could be more poignant when working with families. Physician self-awareness is especially important when working with patients as a partner (solution-building) and with patients in the context of their family.

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