Commentary: Pediatric Psychologist as Investigator in Primary Care

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In 1978, Regier, Goldberg, and Taube (1978) published convincing evidence that the majority of persons in the United States with mental disorders were seen not by mental health specialists but by primary care clinicians. They labeled primary care the “de facto” mental health system in the United States and noted that children and elderly persons were even more likely than adults to be treated solely in the primary care sector.

For six years I have had the good fortune of being involved with one of the first federally funded studies of primary care mental health services for children ever conducted. The Child Behavior Study (CBS) (Kelleher, Childs, Wasserman, McInerny, Nutting, & Gardner, 1997; Kelleher, McInerny, Gardner, Childs, & Wasserman, in press) examined the mental health services delivered to more than 22,000 children in 402 primary care clinicians’ offices. In this study, lessons from a number of pediatric psychology investigators proved invaluable. For example, pediatric psychology research provided the basis for the behavioral screening tool, the practitioner instrument, and the categorizations of psychosocial problems (Burns, Burke, & Regier, 1982; Murphy & Jellinek, 1988). This special edition of the Journal of Pediatric Psychology focuses on the latest contributions of pediatric psychologists to primary care mental health services research.

The articles gathered for this special issue underscore the progress, challenges, and promise of the field for investigations by pediatric psychologists in primary care settings. Progress is demonstrable on a variety of fronts. First, we see researchers moving beyond correlations between medical disorders and mental disorders, or the identification of psychological problems in chronically ill youths. Instead, investigators focused on the range of barriers to improved management of children with, or at risk of, emotional or behavioral disorders in primary care settings, such as lack of diagnostic terminology, instrumentation, and new services. Armstrong et al. (this issue) continue in the tradition of describing a psychological service that enhances the care of chronically ill youths. Drotar (this issue) provides information on the Diagnostic and Statistical Manual for Primary Care—Child and Adolescent Version, allowing investigators across primary care settings to use a common language in their studies, one that will be user-friendly to clinicians. McCain, Kelley, and Fishbein (this issue) provide information on a tool for screening toddlers in primary care settings. Together, all of these pieces are the foundation for future studies of mental health promotion and disorder prevention in primary care for children. As such, they represent considerable progress for pediatric psychology research in primary care, which in the past has largely focused on correlational studies of child psychopathology and risk factors in medical settings (Rae, 1998).

The challenges to conducting research in primary care settings that will improve the quality of life for children and families are substantial. The logistical challenges of primary care research are well delineated (Green et al, 1984; Wasserman, Slora, Bocian, Fleming, & Kessel, 1998). Moreover, studies of primary care interventions for adults with depression suggest the need for long-term strategies...
involving primary care clinicians, community workers, and probably managed care organizations (Goldberg, Kay, & Thompson, 1976; Katon, 1998). Thus, the pediatric psychology studies here are only a first step. To move further, pediatric psychologists will need to expand their research paradigms and methods in specific ways. First, the consumer perspective must be more fully incorporated into research designs, measures, and analyses. Including patient and family views is dramatically altering the accountability of health care providers and managed care organizations. Pediatric psychologists should lead the way in considering family preferences for treatments and satisfaction with care in primary care settings. Schultz and Vaughn (this issue) provide us with insight on one aspect of urban family preferences for primary care clinic involvement in parenting training. Additional research should consider family satisfaction with care and the burden that proposed interventions place on families. In the same vein, we should not forget that primary care clinicians and staff are also our “customers” in developing interventions for primary care settings. Their perspectives will be essential for implementation in the future.

Interventions for primary care practice must be conducted in “real-world” settings. Too often, studies use academic medical centers or even specialty clinics to provide pediatric psychology services. While this is appropriate considering where most such departments are housed, academic settings account for a very small percentage of all primary care visits in the United States each year, and patients seen at such institutions are often not representative (Green et al., 1993; Wasserman et al., 1998). In fact, more than 85% of all pediatric visits occur in office-based practices of community-based primary care clinicians, suggesting that studies examining mental health services to children or even the epidemiology of emotional and behavioral disorders in children should be conducted in community or primary care settings. Nevertheless, research on certain highly selected populations served almost exclusively in tertiary settings will still be generalizable. For example, patients with complex congenital heart disease, major organ transplantation, and cystic fibrosis are still largely cared for in major pediatric referral centers. Lavigne et al. (this issue) provide evidence that some of the best research can be conducted in primary care settings through the use of practice-based research networks such as the Pediatric Practice Research Group in Chicago or the National Pediatric Research in Office Settings (PROS) (Wasserman et al., 1998) network affiliated with the American Academy of Pediatrics. These “laboratories” are ideal locations for the observation of practice and the development of interventions.

Studies in representative settings will likely tell us what we have learned from twenty years of adult studies and a few pediatric studies in primary care (Hankin, Kessler, Goldberg, Steinwachs, & Starfield, 1983; Shapiro et al., 1987; U.S. Preventive Services Task Force, 1996). That is, more studies of risk factors and screening tools in primary care settings not linked to specific interventions are not helpful for primary care physicians. Even if we can improve diagnosis and assessment in primary care settings, the lack of effective interventions frustrates providers and systems and is ethically suspect because children are identified without available treatment. We must move beyond identification issues and into interventions because primary care physicians will not identify problems without effective treatments. Riekert, Stancin, Palermo, and Drofat (this issue) provide an initial step by describing an intervention. This article highlights the need for partnership between pediatric psychologists, with their expertise on child and family interventions, and primary care clinicians, who have longstanding relationships with families and constraints imposed on their space and time in practice.

Last, and perhaps most important, pediatric psychology investigators interested in primary care research must expand their models of intervention research to consider the myriad factors that influence the implementation, dissemination, and conduct of interventions in primary care settings. To date, pediatric psychologists have often limited their studies to family, child, and occasionally school factors that influence use, psychopathology, and outcomes. Among all the studies published during 1998 by this *Journal*, only two studies mentioned possible provider factors and none considered system or practice factors such as location, organization of services, or financing. Ignored in these studies are the provider, clinic, insurance, and neighborhood characteristics likely to be the limiting factors in determining the effectiveness of pediatric psychology interventions, especially in primary care. For example, patient scheduling practices in primary care and the relationship of primary care physician with patient are among the best predictors of recognition and management of psychosocial problems in primary care settings.
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(Gardner et al, 1998; Kelleher et al, 1997). Moreover, significant differences in primary care management for pediatric psychosocial problems are also associated with family agreement with clinician perceptions (Gardner, Childs, & Scholle, 1999). Such findings may help explain why we have so many trials documenting the efficacy of mental health interventions in controlled clinical trials but find few interventions effective in community settings. The limitations of real-world practice have not been adequately explored. Of course, this implies more challenging multi-site studies to introduce sufficient variation.

Although the challenges are many, the promise of pediatric psychology investigators for important research in primary care settings is great. Pediatric psychologists are uniquely qualified to conduct primary care mental health research. Their training in child psychopathology and resilience along with the scientific method makes them better suited than primary care clinicians for research in general and particularly well suited for investigations on intervention outcomes. Pediatric psychologists should play a leadership role in interventions for youths with chronic illness in primary care settings. Moreover, many pediatric psychologists speak the “languages” of both primary care clinicians and mental health specialists. Finally, familiarity and experience in working with interdisciplinary teams is also an important asset in the conduct of primary care research. What is less clear is whether pediatric psychologists and their respective institutions can agree on primary care research as a priority. Many academic pediatricians are moving away from academic medical settings for both practice and research. Hopefully, pediatric psychologists will join them. The alternative is that pediatric psychologists will be so enmeshed in clinical care, teaching, and administration, because of their unique training and talents, that they will not compete effectively with other investigators working exclusively in research arenas, the fate that has already befallen most physician researchers. My hope is that research in primary care will become a priority for pediatric psychologists and their institutions and that pediatric psychologists will lead the way in developing and investigating interventions for use in pediatric primary care settings.

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References


