Commentary: First, AIDE for Pediatric Psychology

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Addressing the state of pediatric psychology as a practice subspecialty, Rae (this issue) provides an excellent overview of the history and current status of the field from a perspective of fiscal travail. He bemoans the current reimbursement system for mental health services, as applied to pediatric psychology, and identifies three promising areas he hopes may lead our field to economic viability. These include: focusing our attention on our market niche (e.g., close alliance with pediatrics, directed toward primary care and chronic medical conditions); prevention of psychological dysfunction; and demonstrating the benefits of medical-cost offset. Rae concludes on a relatively plaintive note, recalling the mournful words of a Depression-era song and urging us to keep the faith.

In this author’s view, Rae’s commentary is partially correct, but far too passive. Pediatric psychologists cannot afford to depend on the largesse of others for the “dime.” We must first “AIDE” ourselves. Rae has essentially recognized that we already have the ability to do this. The agenda must be aggressively pursued.

In this context the “A” is for sound clinical applications. As Rae notes, our field has already developed many assessment and intervention strategies related to everything from infant feeding protocols to problem solving regarding incontinence (e.g., adherence, pain control, hospitalization preparation, school reintegration, parent training). We must continue to innovate and test treatment approaches, prevention strategies, and primary care interventions for the problems most vexing to pediatric practitioners, the patients they care for, and the parents who live with the problems on a day-in/day-out basis.

The “I” stands for integration and refers to Rae’s accurate perception that our survival depends on close interaction with pediatricians in primary care and pediatric subspecialty settings. Such physicians welcome the presence of psychologists with well-founded behavioral assessment and intervention strategies for their most challenging patients. Physicians also like to refer their patients to people they know and in whom they have confidence. Thus, working frequently and in close proximity with primary care physicians or on treatment teams with subspecialists instills a high level of confidence in, utilization of, and high-quality integration of psychological services.

Pediatricians do not share the same defensiveness toward psychologists often encountered among our psychiatric colleagues. We should not find the psychiatrists’ defensiveness surprising. With progressively decreasing interest in psychiatric residencies evident among young physicians, many psychiatric residency slots left unfilled annually, and those that are filled occupied predominantly by foreign medical graduates and physicians “changing career plans” (i.e., finding themselves redirected by their supervisors toward psychiatry when they have difficulty succeeding in other medical specialties), it is no wonder that psychiatrists’ displaced insecurities frequently attach to psychologists. In addition, with their psychotherapeutic training having consisted entirely of the on-the-job postdoctoral sort, with minimal theoretical or behavioral science preparation, psychiatrists increasingly find their employment options limited predominantly to a focus on psychopharmacology. Even that last bastion of psychiatric authority has begun to fall to psychologists, although pediatricians and internists have long prescribed more psychotropic medication than their psychiatrist colleagues.

The “DE” in AIDE stands for demonstrated effectiveness. Although Rae cites a decade-long surge of interest in empirically supported treatments (i.e., interventions supported by statistically significant results in randomized clinical trials), clinical medicine has traditionally had a much more flexible standard for successful intervention. Case studies, qualitative data
analytic techniques, and a variety of other well-established behavioral research methods can also effectively test and document the value of our interventions. Pediatricians untrained in research methods will generally welcome the opportunity to partner in new basic and clinical research with psychologists. In so doing, we further establish the merit and utility of our subspecialty.

A report nearly 25 years old documents the value of the philosophy represented in the AIDE model (Koocher, Sourkes, & Keane, 1979). The article described development of a psychology consultation service to a pediatric oncology service, using two part-time post-doctoral psychology fellows as interveners after the traditional “liaison psychiatry” model had proven suboptimal. At the end of the training year, the head of pediatric oncology created permanent jobs to avoid losing the services his staff had become accustomed to. Today, the clinical service described in that report still survives, directed by a psychologist, with several staff and trainees, and minimal psychiatric involvement.

My two major quibbles with Rae’s approach concern (a) his emphasis on cost offset as a route to proving our value and (b) the plaintive passivity implied in the title of his article. A recent demonstration study based at a health maintenance organization (HMO) documented a positive cost offset of roughly $400 per patient when preventive interventions were routinely offered to newly diagnosed adult cancer patients (Koocher, Curtiss, Pollin, & Patton, 2001). At the end of the study, the HMO management praised the results but declined to institute the moneysaving program based on business strategy factors (e.g., determination that the offset was trivial given the number of patients, turnover among subscribers, and fixed costs of adding employees to provide the intervention). The magnitude of fiscal offset necessary to satisfy most HMO chief financial officers most likely lies well beyond readily available data.

Contrary to endorsing the pitiful and passive plea for Rae’s “dime,” we should instead encourage all pediatric psychologists to move as swiftly as first responders in medical disasters—through preparation by mastering existing clinical applications and working energetically on new ones, by integrating ourselves into the fabric of a pediatric primary care or subspecialty practice, and by keeping careful track of our clinical effectiveness (i.e., if not with ongoing data collection for research publication, then at least for quality assurance and improvement purposes). This active AIDE model will assure that pediatricians continue to think first of psychologists when they confront difficult behavioral challenges in the course of their work.

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References
