THE DIFFICULT PARENT ENCOUNTER

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USPS, March 10 2012, Seattle, WA

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Ideal Encounter

• **Provider**: active listener, not rushed, knowledgeable and competent, (usually assumes quietly compliant parent and child)

• **Parent**: Respected, listened to, communicates honestly and concisely, satisfied with every encounter, able to comply with provider recommendations

• **Child**: Has a condition that has a solution, non-painful experience, participates in the visit
**“Difficult” Encounters**

- 1 in 6 adult outpatient visits are considered “difficult” by clinicians; in military setting 15%.
- Parents report 10-15% of children are “difficult”.
- 15-21% adults have mental health conditions affecting parenting effectiveness; in military ~ 35%.
- Child maltreatment was 42% higher when soldiers were deployed vs. not deployed (Gibbs, JAMA, 2007)

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**Relationships**

**IDEAL**

PEDiatrician or PROVIDer

situation

CHILD

PARENT

**DIFFICULT**

PEDiatrician or PROVIDer

situation

CHILD

PARENT

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**Factors in Difficult Encounters**

- The clinician-parent relationship is strained
- Negative or ineffective parenting strategies
- Cultural differences
- Slow treatment response
- Clinician limitations in knowledge
- Ambiguous boundaries
- Judgmental attitudes
- System or practice level problems
- Time constraints
Factors common to "difficult" adult patients

- More likely to have psychopathology
- Have 5 or more somatic complaints
- Have more severe symptoms
- Use health services more
- Are less satisfied with care

Jackson and Kroenke, Arch of Int Med, 1999

3 Cases

- Challenging Parent: Parent-child mismatch
  high prevalence, low severity
- Impaired Parent: Parental psychopathology
  (such as anxiety, depression, PTSD):
  moderate prevalence, moderate severity
- Dangerous Parent: Unsafe for child
  (neglect, abuse)
  low prevalence, high severity

Case 1

Tommy is a very active 2 1/2 year old who has been "kicked out" of day care because of aggressive behavior toward other children. Father is deployed. Mother reports Tommy has always been a bully. His behavior is causing mother to miss work and ruining the marriage. Mother is at wits end! He does not respond to spanking. He has "beaten up" his younger sibling.
Case 1:
What made this difficult?

- **General**
  - Clinicians know this is more about the parent-child interaction than anything specific to the child, and parents are usually unsatisfied with recommendations.
  - Time constraints
- **Specific:**
  - Parent commenting about negative behavior in front of child
  - Parent attributions of young child’s behavior causing so many problems
  - Severity of complaints about a 2 year old
  - Time constraints

Temperament

- Activity
- Attention
- Emotional Intensity
- Regulation
- Adaptability
- Irritability
- Sensory Threshold
- Approach/Withdrawal

A 3 year old boy with
- *negative emotional intensity*
- *highly reactive*
- *inflexibility*
- *high activity level*

= Difficult Child

= Negative parental response......
= DIFFICULT ENCOUNTER

Negative vs Positive Control

- **Negative Control**
  - Criticism
  - Ignoring child
  - Coercive discipline
  - “stop that” – unclear expectations
- **Positive Control**
  - Social praise with smile, physical affection
  - Limit setting
  - Provide structure
  - Clear expectations
  - Attention
  - Sensitive to possible sadness about parental deployment
Case 2

- Jacob is a 2 year old with extreme head banging and body rocking for past 2 weeks. Labs and EEG normal. Child easily soothed by FOC and day care provider. MOC with flat affect, tearful, slurred speech and slow movements. She has a history of past suicide attempt.

Case 2: What made this difficult?

- General:
  - Parent’s perception
  - Trust and communication
  - Parents ability to act on information
- Specific:
  - Safety concerns (parent’s substance use)
  - Pressure to “fix” the problem
  - Judgmental attitude

Parental Psychopathology

- Children of mentally ill parents are at higher risk of developing MI
  - Genetic and psychosocial transmission
- Parent’s gender does not matter
- 2 parents with MI is likely worse
- Amount of social support predicts outcomes
- Wanting help and using help do not always correspond.
Psychopathology of Military Parents

- Mood disorders
  - 20.8%
- Anxiety Disorders
  - 18%
- PTSD:
  - 6.8% lifetime prevalence
  - 9.8% women
  - 13.8% ADSM
- Military parents have higher rates of MI

Parental Psychopathology

- Psychopathology impacts thoughts, feelings and behaviors
  - Slow cognitive processing
  - Reduced / selective memory
  - Negative appraisals / mistrust
  - Avoidance
  - Intense fear, hopelessness, and rage
- Psychopathology mediates comprehension, learning and action.

Case 3

2nd Clinic Visit:
21 m/o toddler w/unexplained bruising x 2 weeks

MOC concerned. No known trauma. No recent illness.
Sometimes found awake at night, by MOC and BF, sitting in the corner of his bedroom.

PE: bruises to both ears, L>R; bruises to right forehead and cheek.

Lab: CBC, PLT, PT, PTT normal (obtained at first clinic visit)
CASE 3:
What made this difficult?

- **General**
  - Parents present as concerned & credible
  - Diagnosis of trauma, absent history of trauma

- **Specific**
  - Betrayal of trust (two-faced)
  - Child < 3 year at increased risk of fatal abuse

History, history, history

- Absent h/o trauma → #1 historical indicator of abuse
- Child characteristics predisposing to abuse
  - anything that makes a child more difficult to care for
  - anything that makes a child different from the parent’s expectation

21st Century Pediatric Morbidity

- Obesity, mental health disorders, parental substance abuse, ↑ screen time, exposure to violence
- Neurons that fire together, wire together
- Tip the balance:
  - protective factors >> risk factors
Strengthening ALL encounters

- Clarify roles and expectations
- Specify goals of interaction
  - What are previous care experiences
  - What are family strengths and challenges
  - What solutions are within reach
- Ensure lines of communication are clear

Effective Communication

- **Informativeness:** quantity and quality of information
- **Interpersonal sensitivity:** attention to, and interest in the parent’s and child’s feelings and concerns
- **Partnership building:** the extent to which the provider invites the parent and child to participate in the consultation

Examples of Improved Communication

- **Improve listening:** “What I hear you saying is…did I get that right?”
- **Improve partnership:** “It seems to me that we sometimes don’t work together well”
- **Express negative emotion:** “It is difficult for me to listen to you when you use that kind of language”.
- **Increase empathy:** “You seem upset, can you help me understand what you are going through?”
- **Negotiate process of care:** “How do my recommendations fit with your ideas of how to solve these problems?”
Strategies for ALL Difficult Encounters

- Address or frame the problem
- Expand the system of care
- Give it time

CASE 1 The challenging parent

- Address the problem
  - With time constraints, framing this problem may be all that can happen at first visit
- Expand the system
  - Refer for child care, respite, parenting support
- Give it time
  - Ask parent if YOU can call her in one week?

Case 1 Summary

- Parent did not appear to be listening when I discussed child temperament and negative parental control. Left office appearing dis-satisfied.
- On one week phone follow up that I remembered to make, parent had Family Child Care interview set up, and agreed to work with FOCUS on positive parenting.
CASE 2
The Impaired Parent

- Address the problem
  - Communication: clear, curious and caring.
  - Write down goals and plans
  - Share with a 3rd party
- Expand the system
  - Activate all available resources
- Give it time
  - Reduce information – Increase interactions
  - Firm, compassionate, consistent

Case 2
Summary

- Patient’s father adjusted work with command support
- Safety plan was clarified
- Activated social and therapeutic supports for the parent
- Jacob’s problem improved and his care was expanded.

Case 3
The Dangerous Parent

Address the problem

- Active listening: attend to the narrative (what does it tell you that parent does not)
- Be conscious of your persona
- Keep a clear head
  - What would you do if the parent was not there?
  - Be clear of diagnosis “trauma” (knowing what but not how)
  - Be clear about your requirement to report
- Ask parent for their cooperation
- Mindful messaging
- Negotiate plan of 360 care
- Reframe: concern for “trauma” and behavior and language delays; expanding mom’s safety net; respite
Case 3
The Dangerous Parent

Expand the system
- Warm hand off to Pediatric Social Worker
- Child Abuse Pediatrician
- CPS and SW/FAP safety plan
- Ensure adequate follow up
- Ensure contact information is correct for everyone
- FAP liaison and command support

Give it time
- Stay committed to the child and the process
- Be prepared: mom's perception may change (for better or worse)
- Embrace the opportunity
- Exercise continuity of care

Case 3
Summary

Investigative facts: 1 week out
- Restraining order s/p DV
- BF in Batterer's Group
- Mom declined BH/MH
- CPS s/w eye witness
- Child placed in temp foster care

Epilogue: 2 – 3 weeks out
- Court ordered BH services
- Child reunited w/dad
- No CPS dependency
- Mom admits to LE
- Dad & son return together for care

Summary
- When you suspect a difficult encounter
  - Clarify roles and expectations
  - Ensure “best behavior” for communication

- “Embrace” difficult encounters
  - Address or frame the problem
  - Expand the system of care
  - Give it time
References

- Breuner CC and Moreno MA. Approaches to the Difficult Patient/Parent Encounter, *Pediatrics* 2011;127;163.