THE FAMILY IS THE PATIENT

an approach to behavioral pediatrics for the clinician

ALLMOND / BUCKMAN / GOFMAN

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Illustrated

The C. V. Mosby Company

ST. LOUIS • TORONTO • LONDON 1979

Printed in the United States of America

The C. V. Mosby Company
11830 Westline Industrial Drive, St. Louis, Missouri 63141

Library of Congress Cataloging in Publication Data

Allmond, Bayard W
The family is the patient.

Bibliography: p.
Includes index.
1. Pediatrics—Psychological aspects. 2. Sick children—Psychology. 3. Family—Health and hygiene. 4. Parent and child. I. Buckman, Wilma, joint author. II. Gofman, Helen F., joint author. III. Title.
[DNLM: 1. Behavioral sciences. 2. Child development deviations. 3. Family. 4. Pediatrics. 5. Social environment. WS100.3 A439f]
R547.5.A43 618.9'2'00019 79-16622
ISBN 0-8016-0131-2

C/VH/VH 9 8 7 6 5 4 3 2 1 01/A/081

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To

OUR TRAINEES—STUDENTS, INTERNS, RESIDENTS,
and FELLOWS

They have been our faithful teachers

Foreword

Family-focused pediatrics has been given considerable lip service as the desirable way to practice pediatrics. In fact, however, it has been little practiced. In spite of calls by eminent authorities over the past two decades and recent announcements by the Task Force on Pediatric Education, which strongly recommends education of pediatricians in the biosocial and family aspects of child health, to date there has been little practical education of pediatricians in the skills needed for providing family therapy. This text is one of the first written by, and for, pediatricians to help them learn the skills of family therapy.

Reading a book on family therapy can no more produce a skilled family therapist than reading a book on skiing can make one an accomplished skier. It can help, however, both before starting the experience and after one has made some first clumsy attempts. This book avoids the use of jargon and is heavily illustrated with case examples that all clinicians can recognize. Examples of common behavioral problems in physically well children, as well as behavioral aspects of chronic disease, hospitalized patients, and psychosomatic disorders, are presented. The case examples include the actual verbal dialogue between family members and pediatrician. As the authors comment, "verbal dialogue tends to lose something . . . the juices and the flavor . . ." when written down, but the presentation of the cases in this text comes as close to the real thing as the written word can. Behavioral pediatrics is now an "in" word to define the new pediatrics, but it has been hard to define or to point the interested clinician to references that would help. This book is such a help.

Clearly family therapy is not for every pediatrician. This text will help those who are on the fence decide whether they want to obtain the training to do it well. Doing it well requires considerable experience, training under supervision, and skill. We still do not have carefully controlled studies to demonstrate which patients are most likely to be

helped nor how the long-term effects of such therapy compare with other methods of treatment. However, there is so much validity to the cases presented that most readers will find that the methods and results "ring true." For pediatricians who recognize that the family is *the* patient, this book will be a guide to an exciting new diagnostic and therapeutic skill.

Robert J. Haggerty, M.D.

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Harvard School of Public Health;
Visiting Professor of Pediatrics,
Harvard Medical School

Preface

We began writing this book regarding behavioral or biosocial issues in pediatrics in November 1977, nearly 30 years after the Child Study Unit first began teaching pediatricians how to deal effectively with the psychosocial aspects of children's health care. Our trainees (over 200 pediatric residents and 26 fellows) often stated that the training they received from us in this area was the most valuable of any obtained during their medical education. This fact was often made all the more surprising, they added, because of their preconceived conclusion that any rotation in behavioral pediatrics would probably be dull and a waste of time. We knew different, of course. The behavioral realm of pediatrics is both exciting and important, and its teaching can and should reflect that same excitement and importance.

Naturally our specific approaches in teaching pediatricians and working with children have changed and evolved with the years. But regardless of the strategies and techniques used, we have singlemindedly held to the view that pediatricians in training should have expertise in the management of those behavioral and psychosocial issues that appear along with the child himself in the practicing pediatrician's office. Attention to the psychosocial needs of children is as much the responsibility of a pediatrician as the traditional concern for their physical well-being. Both aspects, not just one or the other, exert exceedingly important influences on the health and growth of all children. Pediatricians should therefore have practical, working skills for the handling of both biological and psychological dilemmas in children.

We have attempted to impart to our trainees this practical, working skill regarding the management of children's biosocial needs. Their response to our efforts over the years has been gratifying and enthusiastic. It is increasingly apparent to us as well that the work in which we have been engaged is both unique and successful and that the time has come to share our approaches to children's health and behavior with a

wider audience. This book is intended for pediatricians, family practice physicians, nurses, social workers, psychiatrists, psychologists, and family therapists—as well as teachers and students in all of these disciplines. Since much of our own teaching focuses currently on the utilization of a family approach to children and their problems, we have decided to address most specifically the use of family interviews and family therapy principles by a physician or other health professional engaged in the clinical practice of pediatrics.

To be sure, we are joined by many others in our view that behavioral pediatrics is important and necessary for the training of all pediatric clinicians. This was dramatically verified in a recent publication of the Task Force on Pediatric Education, titled *The Future of Pediatric Education.** The task force was formed because of a recognition that many of the important health needs of infants, children, and adolescents were not being met as effectively and fully as they should be. Members represented ten societies that shared a common concern for the welfare of children (the American Academy of Pediatrics, American Academy of Child Psychiatry, Ambulatory Pediatric Association, American Medical Association Residency Review Committee, and Society for Pediatric Research, among others). Their primary goal was to identify the unmet health needs of children and to point out the educational strategies that would be required to prepare the pediatricians of the future to meet them. The published report was in their words "a distillation of two years of thought, testimony, and research."†

Early in their report, the task force acknowledged the omnipresence of behavioral issues in clinical pediatrics: "During the course of discussion the following issues repeatedly emerged at the core of current problems in pediatric education. They can only be addressed by commitment of talent, space, and money. . . . Biosocial and developmental problems, such as early family adjustment difficulties and school failure, adversely affect the health of many children and adolescents. These problems are serious and very widespread. All pediatricians should have the skill to cope with them."‡ The group further stated that children's

*Report: The Task Force on Pediatric Education. The future of pediatric education, 1978, Evanston, Ill.

†Report: The Task Force on Pediatric Education. The future of pediatric education, 1978, Evanston, Ill., p. viii.

‡Report: The Task Force on Pediatric Education. The future of pediatric education, 1978, Evanston, Ill., p. ix.

health needs are changing such that pediatricians in the future "will be called upon *increasingly* to manage children with emotional disturbances, learning disabilities, chronic illnesses, and other problems of a developmental, psychological and social nature.*

Perhaps most importantly, the task force identified those categories of needs in children most often underemphasized in current pediatric education. Foremost among them were "the biosocial and developmental aspects of pediatrics (early adjustment problems and school failure as well as all those deriving from abnormal growth and development in the child who is chronically ill or is socially, mentally, or emotionally disturbed)."†

A section of the task force report devoted to discussion of biosocial and developmental aspects of pediatrics seemed so pertinent to our teaching and to the writing of this text that we decided to include here a lengthy quotation from that portion of the report:

> By biosocial problems the Task Force means those health problems which are socially induced or complicated by social and environmental factors. These problems are sometimes referred to as "psychosocial" or "behavioral," but the Task Force prefers the term "biosocial" because it indicates that these aspects of child health are as much a part of human biology as those to which the term "biomedical" is commonly applied. The developmental aspects of pediatrics often involve both biomedical and biosocial concerns.
>
> The roles of pediatricians in practice are changing and pediatricians are increasingly being consulted regarding problems of a biosocial and developmental nature. With increasing frequency, the practicing pediatrician is being called upon to aid parents and children in coping with the challenges of modern society. Finally, to be effective in the promotion of healthy lifestyles and in health education, the pediatrician will need to be competent in the biosocial aspects of the discipline.
>
> The increasing national emphasis on primary care and the increasing visibility of biosocial problems have brought about changes in the nature of pediatric practice. Parents report numerous biosocial and behavioral problems in their children, turn most often to pedia-

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*Report: The Task Force on Pediatric Education. The future of pediatric education, 1978, Evanston, Ill., p. 13.

†Report: The Task Force on Pediatric Education. The future of pediatric education, 1978, Evanston, Ill., p. 1.

tricians for help, and express a willingness to pay for the extra amounts of the physician's time required for counseling in these areas. . . .

Practitioners are becoming involved in management of biosocial and developmental problems not only because of the great need, but also because the growth of group practices allows individual pediatricians to pursue areas of special interest. Among the areas of special interest most frequently selected by general pediatricians are those which require a commitment to biosocial and developmental concerns: i.e., behavioral and psychosocial pediatrics, adolescent medicine, the child with handicaps, child abuse and neglect, and community medicine.

About half (54 percent) of young pediatricians rated their residency as providing insufficient experience with psychosocial and behavioral problems; 36 percent rated training in the management of mental or emotional disorders as insufficient. It is understandable, therefore, that pediatricians are expressing a desire for additional training in the biosocial and developmental areas.

The content of experience in biosocial pediatrics should include normal and abnormal growth and development, basic behavioral science information, reactions of children of various ages to illness, education for healthy lifestyles, and the principal literature regarding child development. Residents should also learn about the nature of psychologic and achievement tests, the principal psychological therapies, the principles of psychopharmacology, and the techniques of family counseling. They should be familiar with the developmental characteristics of the parent-child interaction, child care practices, and dysfunctions in parenting.

Residents should learn to manage such family crises as death and bereavement, suicide attempts, sexual assault, accidents, child abuse, birth of a defective child, separation, divorce, abortion, and a wide range of common behavioral disorders. Furthermore, they should be able to work with the family to resolve problems in parenting, well child care, adoption/foster care, school adjustment, and learning. They should be familiar with the role of the pediatrician in the management of disease states in which psychological elements play an etiologic or contributory role. . . .

Residents need to acquire skills in interviewing and obtaining a history from parents, parent surrogates, children, and adolescents. The interview should create a positive relationship between physician and patient while eliciting data leading to the diagnosis of organic or psychosomatic disease. Residents must learn to hear what children are saying.

Another important skill is the systematic observation of behavior and personal interactions in settings in which children are nurtured,

> cared for, and educated. Behavioral observations often offer important diagnostic clues. Developmental and psychosocial evaluation . . . should be part of every thorough physical examination. The physical examination should be an emotionally therapeutic experience.
>
> Empathy and the ability to use subjective personal reactions in the care of patients are additional important skills. The pediatrician's development of self-awareness, particularly of personal temperament and preferences in lifestyle, may enable him or her to become more aware and accepting of the patient's total life situation, respecting the autonomy, privacy, and value preferences of the families served. The pediatrician can often promote healing and prevent biosocial complications by personal concern and kindness.
>
> Other skills include the ability to communicate with parents and the child in the ways which enable them to increase their confidence in themselves and to engage actively in their own health and sickness care.*

We hope that the reader—pediatrician, family physician, nurse, social worker, psychiatrist, psychologist, or family therapist—will find this text responsive to the preceding observations and recommendations, a useful tool for enhancing one's knowledge regarding the biosocial aspects of pediatrics, and a book that may be used for developing specific clinical skills in working effectively with children and their families.

We are very grateful for the unflagging support and professional comradeship offered by our colleagues in the Child Study Unit. Their ideas, skills, and yeoman work efforts have in large part made the writing of this text possible. To each we say thank you. The staff includes: Mary Crittenden, Ph.D., pediatric psychologist; Sarah Dean, M.A., pediatric psychologist; Richard Flower, Ph.D., speech, language, and hearing consultant; Donya Harvin, M.A., pediatric psychologist; Paula Johnson, M.S.N., N.P., clinical nurse specialist; Diana Kennedy, M.S., pediatric psychologist; Marc Lehrer, Ph.D., pediatric psychologist; Alan Leveton, M.D., consulting psychiatrist and family therapist; Jack Obedzinski, M.D., pediatrician and family therapist; Louise Taichert, M.D., pediatrician and family therapist; Alice Whitsell, B.S., educational specialist; and Leon Whitsell, M.D., consulting neurologist and psychiatrist. One other staff member in the Child Study Unit has literally

*Report: The Task Force on Pediatric Education. The future of pediatric education, 1978, Evanston, Ill., pp. 19-21.

made the writing of this volume possible. Our secretary, Nancy Colvin, has tirelessly and expertly nursed this manuscript through its typing and retyping periods, serving not only as typist but also as grammarian and informal reviewer. Her contribution is acknowledged and most appreciated.

Another informal reviewer deserves mention. Nancy Allmond, in the wings, has listened and listened. She has also provided ideas, encouragement, suggestions for revisions, and enthusiasm. Grateful acknowledgment is made of her contributions to the project.

The Child Study Unit has continued to receive considerable financial support over the years from the Division of Maternal and Child Health, Department of Health, Education and Welfare (Grant #MCT-002001-13-0). We are grateful for this steadfast support of our teaching and research efforts. Such funding has played no small part in the development and completion of this text.

Bayard W. Allmond, Jr.
Wilma Buckman
Helen F. Gofman

Contents

Introduction

This text describes a clinical approach that has been developed over the years within the Child Study Unit of the Department of Pediatrics at the University of California, San Francisco. A brief history of that unit will help the reader to glimpse the setting that has nurtured our ideas.

The unit began 30 years ago with two staff members and one trainee. It was established by the late Dr. George Schade, a pediatrician at the University of California, San Francisco; he was one of four pediatricians selected throughout the country in the 1930's to receive 2 years of training with Drs. Frederick Allen and Jessie Taft at the Philadelphia Child Guidance Clinic. Training for the four pediatricians, directed toward increasing their knowledge in the management of pediatric emotional and behavior problems, was supported by the Commonwealth Foundation. The organization hoped through this project to improve the training of many more pediatricians in the management of common emotional and behavioral problems in children. It was explicitly expected that the four pediatricians, following training, would return to their respective pediatric departments in university teaching hospitals and establish teaching programs devoted to this aspect of pediatrics. In 1948 Dr. Schade, with the aid of a small grant from the Commonwealth Foundation and subsequent support from the University of California and its Department of Pediatrics, fulfilled this expectation by formally opening the Pediatric Mental Health Unit. The staff consisted of Dr. Schade himself, a psychiatric social worker, and Dr. Helen Gofman, his first pediatric fellow.

From the beginning, the purpose of this unit was to provide opportunities for pediatricians "to become better pediatricians." Pediatric house officers were helped to understand and manage the behavior problems commonly seen in pediatric practice. Particular emphasis was