Personal practice

Comprehensive management of children on a paediatric ward: a family approach

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SUMMARY A team approach in the comprehensive management of children on a general paediatric ward is described. The team comprises paediatricians, nurses, a child psychiatrist, and a social worker, with a psychologist, play-leader, and teachers making important contributions. In this way members of the team learn from each other, and the paediatrician in training gains valuable experience about the management of children with emotional problems. The team approach is based on the principles of family therapy, but it also uses other forms of therapy—such as behavioural, marital, and individual. Children with severe psychosomatic problems in particular can be helped by such treatment, but other emotional problems are also suitable for management using such an approach.

Frequently emotional problems cause illness in childhood and they can complicate the management of organic disease. In particular, much of the work of paediatricians is concerned with the management of a psychosomatic disorder in which the child's illness may be the presenting symptom of family conflict,¹ maternal illness,² or of problems outside the home. An illness in a child can affect other members of the family, and any treatment should consider not only the needs of that child but also the needs of the parents and siblings. In this paper a family approach to children admitted to a general paediatric ward is described. Hughes and Zimin³ described a similar form of management for children admitted to hospital with psychogenic abdominal pain. Tomm *et al.*⁴ described a family approach in the management of juvenile diabetes, and Lask and Matthew⁵ evaluated the effectiveness of a family approach to childhood asthma.

Family approach to childhood illness

Physical illness in a child, especially if chronic, affects the whole family and can even lead to a breakdown of the family. Conversely, emotional conflict within a family may lead to illness in at

least one child. In all illnesses there is a close relationship between physical, psychological, and social factors. The search for a single cause, physical or psychological, is often fruitless. An understanding of the components of a child's world, and of the ways in which his symptoms fit into the complex and constantly changing pattern of family relationships helps to plan and give effective treatment. If family conflict is a cause of the child's symptoms or if it is responsible for maintaining them, family therapy is indicated.

Family therapy. Despite controversy about the definition of family therapy, it is agreed that its distinctiveness lies in the use of the concept of the family as a social system that may cause or aggravate the child's symptoms. The aim of treatment is to alter the family dynamics. Lask and Kirk,⁶ and Minuchin and Fishman¹ gave full accounts of family therapy in paediatrics.

The ward and the patients. Our ward contains 20 beds with 8 cubicles that can accommodate parents. The family can visit at any time.

The team comprises paediatricians (including those in training), a psychiatrist, nurses, a social

worker, a psychologist, a play-leader, and teachers. The team meets each week for about 90 minutes under the chairmanship of the psychiatrist to discuss the social and emotional needs of all the children on the ward, regardless of the medical diagnoses. The psychiatrist and social worker join the paediatricians for a full ward-round at least once and occasionally twice a week.

Children with a wide spectrum of illnesses and conditions are admitted to the ward—such as physical or mental handicaps, metabolic disorders, collagen diseases, acute illnesses, and psychosomatic disorders.

If there is a possibility that emotional factors contribute to or result from the illness, the social worker or psychiatrist joins the paediatrician for an interview with the family. Although these early interviews are concerned mainly with diagnosis and formulation of the problem, it is not possible to separate the process of diagnosis from that of treatment. Definition of the problem is often the start of treatment.

During the first year the psychiatrist or social worker was closely involved in the assessment and management of about one-third of the children and their families (Table 1). Children needing closer involvement with the psychosocial team generally stayed longer in hospital. Two-thirds of the children had come some distance, having been referred for a second or even a third opinion because of the complexity of diagnosis and treatment. Even in children referred from within London, one-third of them had already been seen by at least one consultant (psychiatrist or paediatrician). In many instances the importance of psychological factors in the causation of symptoms had been suspected by the referring doctors but the parents had been unable or unwilling to accept this opinion.

Classification of cases requiring close involvement of psychosocial team. To illustrate the types of case

Table 1 The patients

	Total children n=286	Referred for formal psychosocial assessment n=96 (34%)	Not referred n=190 (66%)
Sexes			
Boys	153 (54%)	50 (52%)	103 (54%)
Girls	133 (46%)	46 (48%)	87 (46%)
Total admissions	341	116	225
Average length of admission (days)	16	33	7
Average age (years)	5.1	6.1	4.6
Origin of children			
London	155 (54%)	30 (31%)	125 (66%)
Elsewhere	131 (46%)	66 (69%)	65 (34%)

Table 2 Diagnostic categories

Problem	Boys (n=50)	Girls (n=46)
Psychosomatic, n=30 (31%)	10	20
'Periodic syndrome'	2	11
Soiling	4	3
Gross obesity with severe emotional problems	3	4
Short stature due to emotional deprivation	1	—
Anorexia nervosa	—	1
Psychogenic faints	—	1
Adaptation to physical illness, n=38 (40%)	25	13
Relationship between parents and their under 3-year-old children, n=16 (17%)	8	8
Mental retardation, n=9 (9%)	6	3
Other, n=3 (3%)	1	2

referred we have classified the 96 children seen during one year into 5 groups (Table 2).

Psychosomatic

Any classification of diseases into those that are psychosomatic and those that are not is bound to be arbitrary and potentially misleading. Physiological, psychological, and social factors are important in the aetiology and maintenance of a wide range of conditions currently regarded as mainly of organic origin. The area of 'psychosomatic relationships' in childhood has been comprehensively reviewed by Graham.⁷

In this category we included those conditions in whose aetiology we judged psychological factors to be of prime importance. About one-third of the children referred for detailed psychosocial assessment were in this category.

The term 'periodic syndrome' was used for the frequent occurrence of headaches, vomiting, abdominal pain, limb pains, and fever, singly or in association, as defined by Apley *et al.*⁸ 'Soiling' referred to constipation with overflow, or voluntary defecation in inappropriate places, or both.

Problems of adaptation to physical illness

This group made up the largest number of referrals and comprised children and their parents who were finding it difficult to cope with chronic illness or physical handicap.

The intellectual, emotional, and social development of the child can be influenced directly by (1) the basic illness,⁹ (2) the family's reaction to it,¹⁰ or (3) factors associated with treatment—such as separation, isolation, immobilisation, and medication.¹¹

Problems of relationships between parent and child

These children were under age 3 and had a combination of at least 2 of the following symptoms—screaming, vomiting, sleep problems, feeding prob-

lems with or without failure to thrive, and toddler diarrhoea. Organic causes were excluded, and a disturbance in the relationship between the child and parents was evident.

Mental retardation

Nine children were referred for help with problems associated with mental retardation—such as parental rejection or ambivalence, inability to accept the diagnosis, management difficulties, and the need for advice about education and, in adolescence, sexuality.

Others

In 2 of these, the main family concern was about finance. The third case was a child with headaches in whom the psychiatrist had excluded a psychological cause and the ophthalmologist diagnosed myopia of sudden onset.

Management. At the weekly meetings and ward rounds, the team discusses the relative contribution of physical, psychological, and social factors to the child's illness, and plans management accordingly. The methods of management most commonly used, and defined in the Appendix, are shown in Table 3 according to diagnostic category. We have included the category 'organic disease' to emphasise that our approach applies to all the children on the ward whether or not psychological or social problems exist. If, after at least one meeting with a family suspected of having important emotional problems, an adequate assessment has been completed, the choice of further modes of therapy (individual, marital, continuing family therapy, etc.) is made, in consultation with the psychiatrist and social worker, who also advise on which members of the team should be involved. The choice of such members will depend on their skills and experience, as

well as on the special needs of the child and his family.

Case illustrations. We give an example of each diagnostic category.

Psychosomatic problem

Sheila, 12 years of age, was admitted for investigation of severe headaches of several months' duration. Physical examination and investigations showed no organic causes. Simultaneous preliminary enquiries into emotional aspects indicated no overt disturbance, but once the whole family had been interviewed important factors came to light. Sheila and her father had a very close relationship and her mother was on the periphery of the family with a job that kept her away from home from 7 p.m. to 4 a.m. The father, Sheila, and 6-year-old brother denied their evident resentment at the mother's absence. There clearly was marital disharmony, but its nature was difficult to explore because the parents deflected observations about themselves and would only discuss Sheila's symptoms. Because of their denial the conflict had remained unresolved, and had led to Sheila's symptoms. Once the family denial was challenged, the headaches disappeared, and the marriage then became the focus of lengthy treatment by the psychiatrist and social worker. An additional benefit resulting from the treatment was that the father's long-standing and much investigated weakness and paraesthesiae of the left arm and leg resolved.

Problems of adaptation to physical illness

Matthew, aged 8, the youngest of 5 children and the only boy, had intestinal lymphangiectasia diagnosed in early childhood. Initially the parents were given a poor prognosis and became overprotective, giving in to his every demand. When Matthew was 5, another

Table 3 Use made of various methods of management

Management	Psychosomatic illness	Problems			
		Adaptation to physical illness	Relationship between parent and child	Associated with mental retardation	Organic
Explanation	Frequently	Frequently	Frequently	Frequently	Frequently
Counselling	Rarely	Occasionally	Occasionally	Frequently	Occasionally
Individual therapy with parent	Occasionally	Frequently	Frequently	Occasionally	Rarely
Individual therapy with child including play	Occasionally	Frequently	Rarely	Occasionally	Rarely
Family therapy	Frequently	Occasionally	Occasionally	Occasionally	Rarely
Marital therapy	Frequently	Occasionally	Frequently	Occasionally	Rarely
Behaviour therapy					
Modelling	Rarely	Rarely	Frequently	Occasionally	Rarely
Reward schemes	Occasionally	Occasionally	Rarely	Occasionally	Rarely
Relaxation and desensitisation	Occasionally	Occasionally	Rarely	Rarely	Rarely
Practical help	Occasionally	Frequently	Occasionally	Frequently	Occasionally

physician gave a more hopeful prognosis and stressed the importance of continuing the special diet. This change in outlook led to resentment by the rest of the family towards Matthew because of the 'sacrifices' they had made for him. From the family interviews it became clear that the parents had used the diet as a means of discipline, and had threatened Matthew with the need for further hospital treatment with the result that he developed a needle-phobia. Matthew had become the scapegoat for the other problems in the family and had developed a poor self-image, with low school attainments.

In the course of a few further sessions with the family, the social worker was able to help them to improve their handling of Matthew. The psychologist established a reward-based remedial reading programme which improved Matthew's competence and raised his self-esteem. A medical student, supervised by the psychiatrist, eliminated the needle-phobia by desensitisation.

Problems in relationship between parent and child

Michael, a 2½ year-old child, was admitted from the casualty department for investigation of frequent respiratory infections, failure to thrive, and behavioural problems. The adults accompanying Michael were at first thought to be his parents, but later proved to be the grandparents who had usurped the parents' position. The parents were young and immature and their self-confidence had been undermined by the grandparents. Michael had become the centre of a family conflict because the paternal grandmother wanted the child in order to secure a new marriage. She resented her son's marriage and despised her daughter-in-law. Michael's failure to thrive and the behavioural problems were his response to the situation.

The aims of treatment were to separate the parental and grandparental roles and encourage the parents to achieve greater independence. It was hoped that an appropriate nuclear family would be established, and the relationship between the grandparents and parents be improved so that the grandparents could face the loss of Michael.

The social worker and paediatrician saw the parents on their own and they also had regular joint meetings with the parents and grandparents to tackle the intergenerational problems. 'Modelling' of appropriate parental behaviour by the nurses helped both generations to improve their handling of Michael. Michael spent several trial periods at home, each one of increasing duration, before he was discharged. Close support of the family by the ward team was necessary in order to prevent relapse.

Mental retardation

Veronica, the first child of parents in their late twenties who had had difficulty conceiving, was born with multiple handicaps including microcephaly, blindness, and dislocation of the hips. When these diagnoses were confirmed, the mother became overprotective, withdrawn, and agoraphobic. The father, shaken by the severity of his daughter's handicaps and resentful of his wife's reaction, opted out of his family responsibilities.

Treatment of the family by the social worker and paediatrician helped both parents to share their disappointment and adjust their expectations for Veronica's future. Specific help with handling was needed and included the use of 'modelling' by the nursing staff. Another aim of treatment was to strengthen the marital relationship so that the parents could share their responsibilities rather than work against each other. Treatment was successful in improving the quality of the marriage, and of Veronica's care by her parents.

Outcome. The outcome of these 96 children and their families is summarised in Table 4. In each case the social worker and psychiatrist worked closely with the family's assessment and management. Because of the great variety of problems it is not possible to gauge outcome by simple criteria. Instead, for each case a definition of improvement or deterioration was prepared before the follow-up. The information on outcome was obtained between 12 and 24 months after discharge from the ward. For those children who at the time of review were still attending the outpatient clinic, this information was obtained by the psychiatrist. For those no longer attending as outpatients, information was requested from the general practitioner or paediatrician currently in charge. Data are available for 95 of the 96 cases.

57 (60%) out of 95 children were rated as improved, the condition of 3 (3%) had deteriorated, and in 35 (37%) there was no significant change.

Treatment was particularly successful (75%) in

Table 4 Outcome for 96 cases requiring close involvement of psychosocial team

Problem	Better (n=57)	No change (n=35)	Worse (n=3)	Not known (n=1)
Psychosomatic (n=30)	18	11	1	0
Adaptation to physical illness (n=38)	21	15	1	1
Relationship between parent and child (n=16)	12	4	0	0
Mental retardation (n=9)	4	4	1	0
Other (n=3)	2	1	0	0

children who had difficulties in their relationship with parents. The least successful was the group with problems associated with mental handicap, in which only 45% had improved. The improvement score for the psychosomatic group was 60%, that for the 'adaptation to physical illness' group 55%.

Discussion

Paediatricians are reluctant to admit children to hospital because of the danger of serious emotional repercussions,¹²⁻¹³ although Rutter¹⁴ has challenged this view. Although we are aware of the potential danger, we find that hospital admission can be an effective means of exploring and resolving various complex family problems. During admission it is easier to hold repeated family interviews for diagnosis and treatment. Furthermore, the admission tends to be seen as a critical step by the family in the child's treatment, and such a time of crisis presents an excellent opportunity for bringing about a positive change in family relationships. Admission can also be a valuable method of helping chronically ill or handicapped children and their families to achieve a better adjustment to their condition. During this time, the parents are relieved of the day-to-day care of their child, and are in a better position to see more clearly how the child's condition is affecting their marriage and the family.

For admission to be therapeutically effective, the staff attitudes and the milieu of the ward are vital. The staff need to be not only caring and uncritical in their approach to the family, but should also be able to understand and accept criticism and hostility. They need to be wary of undermining parental self-confidence. The opportunity for the parents themselves to be 'parented' must be provided, as must the opportunity for parents to learn new ways of managing their children. Staff should be trained to adopt these caring attitudes, and to observe and report their observations of the family to the rest of the team.

A doctor confronted by a child whose symptoms may be emotionally determined needs first to convince the parents that such a possibility should be explored. In our practice if a diagnosis of a 'psychosomatic' disorder seems likely, a joint interview between the family and the paediatrician, together with the child psychiatrist or social worker, is arranged early in the admission. We explain that while carrying out investigations to exclude certain organic conditions we plan at the same time to explore the possibility that stresses in the child's life may be responsible for the symptoms. At this stage, parents often find it helpful to have an explanation of the mechanisms whereby stress can cause symp-

toms and to be advised how common such responses are. There are important advantages in the early involvement of the social worker or psychiatrist. This *joint* approach allows a gradual transition both in the focus of treatment and in the family's understanding of the child's illness from the organic to the psychological. The alternative approach of delaying serious consideration of psychological factors until all possible organic diagnoses have been excluded has certain disadvantages. (1) Such an abrupt change of emphasis can lead the parents to reject the possibility of psychosomatic disease. (2) They may accept the possibility of psychosomatic disease but interpret it as unimportant compared with the feared organic disease, and therefore as one not needing further treatment. (3) Although they may accept the diagnosis of psychosomatic symptoms, the parents may see the problem as solely that of the child rather than that of the whole family. (4) The delay in reaching the diagnosis may unduly prolong hospital admission and the parents may then for understandable and realistic reasons demand discharge before a therapeutically effective relationship can be established for continuing outpatient treatment.

Continuing treatment of the family by the psychiatrist or social worker jointly with a member of the paediatric staff, consultant or registrar, has the following advantages. (1) It enables both organic and psychological factors, and their relationships, to be discussed with the parents with greater professional expertise. The tendency during early interviews, for the family to continue to seek organic explanations for the symptoms can be more effectively dealt with. (2) The continuing involvement of the paediatrician helps to emphasise his concern for the family, his recognition of the importance of the symptom, and his awareness of the need for treatment. (3) The presence of paediatrician and social worker or psychiatrist may help the family to appreciate the unity of body and mind. (4) The use of therapists of the opposite sex can help families communicate more openly because different members of the family may find it easier to talk to a person of one sex rather than the other. Moreover, an effective working relationship between the therapists serves as a useful model of communication.¹⁵

This family approach is used not only for the management of psychosomatic disorders but also for that of the other diagnostic categories listed in Table 4.

Many paediatricians have acquired expertise in the handling of emotional problems, and in their work have co-operated with and learnt from child psychiatrists.¹⁶⁻¹⁸ The approach outlined in this paper

provides a useful opportunity for paediatricians in training to gain experience in the diagnosis and management of emotional problems of children and their families. As well as having detailed discussions of each family with the psychiatrist and social worker, they also have the novel experience of being involved in continuing joint family treatment with those professionals who have expertise in such work. The social worker and psychiatrist gain in expertise through team work with paediatricians and their work becomes more effective. Nurses in training also benefit from their involvement in the process of diagnosis and treatment. For the members of the team to gain these educational benefits it is essential that the social worker and psychiatrist be recognised as equal members of the team. Indeed, without such recognition the approach would be unlikely to succeed in its therapeutic aims.

The approach described in this paper which combines several disciplines and aims to work with the whole family is bound to encounter problems. Perhaps the main one is the time required from various members of the team, but intensive work with families for a limited period is likely to save the time of professionals in the long run. Another problem deserving mention is the friction among members of the team which can be created by disturbed families who have a capacity for dividing members of staff, playing one off against another. Such problems are magnified when doubt about the relative importance of organic and psychological factors cannot be resolved quickly. The family approach to treatment is likely to be threatening, particularly to those members of the family who, having previously regarded the problem as entirely within the child, have become aware of their own contribution to the child's symptoms. Under such circumstances the parents' anxiety and distress may show itself as aggression and lack of trust. Handling these reactions can be stressful to the staff, and regular team discussion is essential to support them and enable them to continue to work effectively with the family. Difficulties may also arise when several disturbed families are being treated alongside children requiring intensive nursing care for organic disease. Another problem which concerns the medical and nursing members of the team more than the social worker and psychiatrist is the relative slowness of response of some of the more disturbed families. Paediatricians and nurses have become used to seeing a quick response to the powerful therapeutic agents now at their disposal and may find it difficult to adjust their expectations and continue with tenacity and understanding through long and difficult phases of treatment.

None of these problems has proved insurmount-

able. There are however, circumstances when this family approach cannot be used or when it breaks down: one or both parents may refuse to co-operate, or the family may be so chaotic that it lacks the discipline for making repeated attendances. For families in which there is a paranoid illness or violence, more careful consideration needs to be given to the applicability of family treatment, although it is not necessarily contraindicated.

The assessment of our first year's work as a team has been retrospective and is open to criticism. The results give only a crude indication of what has been achieved. Nevertheless, despite the complexity of the problems treated, the outcome seems to compare favourably with that of other forms of psychiatric intervention.¹⁹ We have not had to transfer a child for psychiatric inpatient care, but if we had, such care would not have differed substantially from the management we describe. A further three years' experience has allowed us to refine the approach despite inevitable and regular changes of junior paediatric staff.

Appendix

Explanation. This may seem self-explanatory. In fact it is recognised that patients and relatives often fail to understand the explanations given them by their doctor,²⁰ who may have been too didactic in his approach, or may not have recognised that the patient or relative was too 'shocked' to take in the information given, or may for other reasons have failed to communicate clearly. For explanation to be successful, a two-way process is required in which the doctor will not only communicate the facts, but also help the parent or child to ask questions, express anxieties, and admit any failure to understand.

Counselling. This involves giving advice about educational, marital, and personal difficulties. It differs from psychotherapy in that it is directive, and aims to provide help to overcome immediate difficulties by guidance and environmental manipulation.

Individual psychotherapy. This is a method of treating an individual based on psychological rather than on physical techniques. It differs from counselling in being nondirective and aims to help the patient to find a way of resolving his own problems. It varies in complexity from simply helping the patient to express his worries to more complex psychoanalytically-orientated techniques. Individual psychotherapy may be used for parents, in which case talking will be the main mode of communication, or for children, when talking, drawing, or play may be used.

Whole (conjoint) family therapy. This is the psychotherapeutic treatment of the whole family together (that is 'conjoining' of the generations) aimed at improving the functioning of the family, and thus relieving children of stress arising from family dysfunction.

Marital therapy. This is the psychotherapeutic treatment of the marital partners, aimed at improving the quality of the marriage.

Behaviour therapy. This refers to a variety of treatment methods based on the theory that all behaviour is learned. Thus symptoms may be considered as maladaptive behaviour acquired by learning, which can be treated by learning a different behaviour. Specific behavioural techniques are:

Modelling

This is the demonstration of behaviour. A nurse may model for a parent how to handle a child's temper-tantrum, or feeding problem.

Desensitisation

This is the process of substituting a response, such as relaxation, which counteracts anxiety. In this way the unlearning or deconditioning of psychophysiological responses—such as tension headaches—or of pure psychological responses—such as phobias—may be achieved.

Reward schemes

The use of rewards to encourage desired behaviour—for example a child who soils because he is afraid to use the lavatory may be given a reward for just sitting on the lavatory. Once he has overcome his fear, he is rewarded for the appropriate use of the lavatory.

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