Beyond Mothers and Children: Finding the Family in Pediatric Psychology

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Pediatric psychologists think developmentally. To understand where our field is now and where we are heading, we must be aware of where we have been. The enormous change in the American experience of childhood in this century is perhaps best illustrated by the following true story. A few years ago Dr. John Kennell, a pediatrician best known to psychologists for his work with Dr. Marshall Klaus on parent-infant bonding (Klaus & Kennell, 1976), related this conversation he had with his 6-year-old grandson:

“What was your favorite video game when you were my age, Grandpa?”

“When I was your age, there were no video games,” Dr. Kennell replied.

The child considered this for a moment, then asked, “Well, what was your favorite TV program when you were my age?”

“When I was your age, there was no TV,” came the reply.

There was a pause as the child digested this idea, then he asked, “When you were a little boy, was there fruit?”

This amusing story does not seem so far-fetched when we consider what life was like in midcentury America. There were no interstate highways, automatic teller machines, video games, home computers, copy machines, VCRs, microwave ovens, or fast food. There was no air conditioning. Television was a new invention, and few families owned one. Children were to be reared in a two-parent family consisting of one set of biological parents and their children. Adoptions were generally kept secret. Unwed motherhood, homosexuality, and alcoholism were shameful topics discussed only behind closed doors. There was no sex education in schools. Divorce was taboo, and most people had never heard of marijuana. Racial segregation was legal and interracial marriage was illegal. If a woman with children worked outside the home, she was pitied because her husband was not a good provider. Women with serious careers did not marry.

In pediatrics, antibiotics were newly available and IM penicillin was cheerfully administered to children for all sorts of infections without any knowledge of the potential for sensitivities or the development of resistant bacterial strains. There was no 911 emergency response system, no organ transplantation, no dialysis, no treatment for cancer. Humans were thought to have 48 chromosomes, and DNA had not yet been discovered. The concept of child abuse did not exist, but doubt was beginning to be cast on the syndrome of spontaneous subdural hematoma, which had been described in the literature (Caffey, 1946).

Children with physical and mental disabilities were routinely excluded from school. If their disabilities were severe, they were institutionalized—permanently. Iron deficiency anemia and polio were among the top pediatric problems. (There was no iron-fortified infant formula and no polio vaccine.) Infectious diseases accounted for the majority
of pediatric hospitalizations, and children’s hospital stays were long. Parents were allowed very limited contact with their hospitalized children (Douglas, 1975; Knudson & Natterson, 1960; Quinton & Rut-ter, 1976). (One of my senior pediatric colleagues recalls working in a hospital where parents were only allowed to visit from 2:00 to 4:00 on Sunday afternoons.) Physicians were treated like gods. Nurses (who were almost always female) stood and gave up their chairs when doctors (who were almost always male) entered the room (Campbell, 1973; Nemir, 1978). Medical personnel routinely lied to their patients of all ages, concealing serious illnesses and poor prognoses (Krant & Johnston, 1978; Kubler-Ross, 1972). Physicians smoked.

Psychology was flourishing, having been given a boost by its use in the military in World War II. Mental health was a brand new concept. Ideas about child rearing were moving away from the Watsonian model (Don’t pick up the child; you’ll spoil him; Watson & Watson, 1928) to an American revision of psychoanalytically based ideas popularized by the energetic pediatrician, Benjamin Spock, through his new and widely-read first edition of Baby and Child Care (Children need love. Trust your instincts as a parent; Spock, 1946).

Pediatric psychology did not exist, but the groundwork was being laid by a group of child analysts at the Tavistock Clinic in London. Spearheaded by John Bowlby, and bolstered by the work of Rene Spitz (Spitz, 1945; Spitz & Wolf, 1946) in France, on institutionalized children, and Mary Ainsworth (1967), in Uganda, on children’s reactions to strangers, this group had become interested in children’s reactions to separation. Children separated from their parents and taken to safety in the English countryside were unexpectedly found to show more adverse psychological reactions than children who remained in London with their parents during the wartime blitz. This work eventuated in the publication of Bowlby’s monograph, Maternal Care and Mental Health, by the World Health Organization in 1951. Despite Bowlby’s acknowledgement on page 1 of the importance of fathers and siblings, the major thrust of the work emphasized the central role of mother-love and maternal contact for psychologically healthy development. James and Joyce Robertson extended this work to look at the effects of the separation of hospitalization on children (1953). Again, it was the separation from the child’s mother that was emphasized as psychologically damaging.

The Emerging Field of Pediatric Psychology

When the field of pediatric psychology was founded less than 20 years later, in 1968, psychologists were still strongly tied to a view of children’s mental health which held that mothers were central to children’s psychological development, for good or for ill. When I started my career in this field in 1971 the major issues for pediatric psychology were children’s rights issues (Seagull, 1978, 1982) such as fighting for the child’s right not to be separated from parents during hospitalizations and painful procedures; advocating for children’s right to be told the truth about their illness and procedures at a developmentally appropriate level (Koocher, 1974; Waechter, 1971); and spreading the word that child abuse did exist, and that pediatricians and psychologists had a responsibility to do something about it (Keith-Spiegel, 1973).

I think we were eventually quite successful on all three counts. In fact, thinking in pediatrics has changed so much that, in sharp contrast to the old practice of keeping the parents out, nowadays, if parents are not very much in evidence during a child’s hospital stay, pediatricians and nurses are worried—“Where are the parents? Why aren’t they here?” Inadvertently aided by the pressing need for more assistance in caring for children in short-staffed hospitals, we have convinced the pediatric establishment to want and welcome the presence of parents during children’s hospital stays.

With regard to honest communication with children, we now find the very youngest children are proud to learn to pronounce the name of their disease. The days when a child died alone, isolated from family because everyone knew the child was dying, but no one would talk about it, are, happily, long gone (Karon & Vernick, 1968).

Child abuse, unfortunately, is still very much with us, but at least we no longer think incest is rare and exotic. Furthermore, every state in the nation has mandatory child abuse reporting laws and some sort of child protection agency to which professionals must report.

In the 1970s a number of developments occurred that were to have a major influence on our work. First, the rise of feminism led women to question whether maternal work outside the home was really damaging to children’s mental health, as they had been led to believe, thus stimulating research on the effects of maternal employment and alterna-
Recent Trends and Needs

Over the past 20 years the evidence supporting a biopsychosocial and highly ecologically contextualized model for understanding human development and behavior has continued to build, from Rutter’s (1972) fine work revisiting the notion of maternal deprivation right up to the present—such as the careful work of Reed Larson (Larson & Richards, 1994) and colleagues at the University of Illinois on emotional transmission in families. They find, for example, that fathers’ negative mood at work predicts negative mood in mothers and adolescents a few hours later, in the evening, but that mothers do not pass emotions from work to home. In our own field, we are increasingly seeing research reflecting a family perspective—work by Anne Kazak (e.g., Barakat et al., 1997; Kazak, 1989, 1997; Kazak et al., 1997; Kazak, Blackall, Himelstein, Brophy, & Daller, 1995; Kazak, Segal-Andrews, & Johnson, 1995), Alexandra Quitter (e.g., Quittner & DiGirolamo, 1998; Quittner et al., 1998; Quittner, Glueckauf, & Jackson, 1990; Quittner & Opipari, 1994), and Jan Wallander (e.g., Roberts & Wallander, 1992; Wallander & Varni, 1998) readily springs to mind.

I would like to be able to say that over this same time period clinical training and intervention for working with children has seen a significant shift toward more systems-level thinking, but I do not think this is true. Year after year we have been fortunate to have the pleasure of accepting into our predoctoral internship program some of the top students in the country from the very best graduate schools. They come to us because they want to learn to practice pediatric psychology from a systems viewpoint. Yet despite this self-selection of students with an interest in family work, year after year we find these top students coming to us with little or no clinical experience in working with whole families. It is as if, in practice, our training programs cannot get past the old ideas of the 1950s, and fall back on seeing mothers and children.

The membership of present-day families is often complex. Single-parent families, blended families, gay/lesbian families, and other configurations are so common as to make the married, biological family unit of the 1950s the exception, rather than the rule in today’s practice of psychology. In order to be maximally helpful to children, we must take the time to find out who is in the child’s family. This means that prior to the first session the clinician must spend enough time on the phone with a family member (usually a parent) to record an accurate genogram and to determine who lives in the household. That clinician must be well enough trained to make a decision about who should come to the first appointment and to successfully negotiate this with the parent making the call. This process does require more effort than letting a secretary handle the calls and make the appointments, but being too lazy to bother including the appropriate family members in the initial assessment of the problem is as self-defeating as being too lazy to toilet train a toddler! It only seems like less work in the short run.

Despite the diverse membership of groups that define themselves as a “family,” the biological reality remains that every child has been fathered by someone. If that person retains a role in his child’s life, serious consideration should be given to including him in the treatment of his child, regardless of whether he is still in partnership with the child’s mother. (The same, of course, applies to mothers in families in which the child is being raised by his or her father.) In the simplest case in which the father lives in the household with the mother and child, failing to include him in his child’s treatment is both disrespectful to his role in the family and counterproductive to the success of treatment. That this is a new idea to many doctoral students from good programs leads me to wonder why they have not been seeing fathers in their practicum experiences. Why are we, in the daily practice of our profession, not more welcoming to fathers in families that have a father? Why are we so ready to accept the mother’s proffered, “He can’t come in?”
Do we really believe that fathers and other family members in the home (e.g., mother’s partner, grandmother, siblings) are so unimportant? Or are we just avoiding the extra work involved in making a place for them in our treatment? Meeting with whole families does mean that we must be more flexible in adjusting to the family’s needs for realistic appointment times that respect the work schedules of adults and the school and activity commitments of children. This often means working evening or weekend hours. It also means that we must develop skills in making the family members we need to meet feel not only invited, but vitally important to the child’s treatment. In most cases we ask all the persons currently living in the same household with the identified child patient to come to the first meeting. We do this for assessments, as well as for treatment cases. Explaining that meeting the family will help us to do a better job of understanding the child results in full cooperation from most families because it makes sense to them and conveys our sincere interest in doing the best possible job. A negotiation may then ensue regarding possible appointment times, during which it is imperitive to make clear that if the requested family members cannot come at the arranged time, the family should recontact us to change the appointment, rather than appear with someone missing. At times it may be necessary to speak directly with a reportedly reluctant father or other important family member to give information and answer questions. Interestingly, simply asking to speak with this person often results in a change in the apparent resistance being offered, even if the proffered conversation does not take place. When this occurs, it is important to note, as further exploration of the dynamic involved may provide useful insight into how the family functions.

All of this negotiation before the first meeting represents additional unbilled time and work for the clinician. Is it really necessary? To address this question, let me borrow, for a moment, a concept from industrial-organizational psychology, known as Pareto’s Law or Pareto’s Principle, “the law of the vital few and the trivial many,” better-known as the 80/20 rule (Zemke, 1986). Vilfredo Pareto was an economist and sociologist born in France to Italian parents, who studied the distribution of wealth, which, in turn, led to the development of mathematical models for describing uneven distributions (Pareto, 1927/1963). His observation that 20% of the people control 80% of the wealth was later applied to industrial quality control by management expert J. M. Juran (1964), and “Pareto analysis” and the “Pareto Principle,” have become standard ideas that continue to be cited in textbooks on management and quality control (e.g., Dilworth, 1993; Moore & Hendrick, 1977). The central idea applicable to our discussion can be summarized as follows: “In any series of elements or variables, a small fraction of the elements account for most of the effect; you can get a lot of outcome from very little effort if you know where to concentrate your effort” (Zemke, 1986, p. 59). When applied in a business context, the rule predicts, for example, that 20% of the sales force will make 80% of the sales, 80% of the griping will come from 20% of the employees, 20% of a company’s products are responsible for 80% of its volume of sales, and so on.

We can apply this idea to our work by hypothesizing that 80% of our referrals come from 20% of the populations being seen by our referral sources. In other words, 80% of parents can handle whatever issues arise in their children’s adjustment and behavior, including coping with illness, by applying information and advice that they get from their family and friends, the child’s physician and teacher, good books, and the occasional quality television program on child development. If their child has a serious or chronic illness, they also get information and help from multidisciplinary health care team members, support groups, special educators, and specialized patient education resources. Those who are referred to us are the other 20%. In a large referral center, the work site of many pediatric psychologists, the distribution is probably even more skewed, as we tend to be referred the most difficult cases—cases that have already received previously unsuccessful interventions. With this population of challenging cases, we are lucky if even 20% can benefit from the more straightforward interventions—parent education, positive reframing, and rearrangement of reinforcement contingencies. This leaves us in need of more sophisticated interventions for the other 80%.

Given the probability that most referred pediatric psychology cases are likely complex, I would argue that we need to step back and take a larger systemic perspective as we begin the clinical assessment of any referred child. In order to gather the most useful data in the shortest period of time, we must use multiple data sources. In most cases these would include the health care team, school or preschool, and the child’s whole family, not just the re-
ferred child and mother. In a high percentage of cases, the most efficient and effective intervention will involve both parents (or the adults who live in the home, such as a parent and that parent’s partner, or parent and grandparent). Siblings will also often be important to include, at least some of the time. But we cannot find out if we do not at least meet the whole family together once. If, on the other hand, we make a sophisticated clinical assessment that includes attention to multiple systemic levels, we can devise an effective intervention that will involve 80% less effort because it is appropriately targeted.

Consider the following common family dynamic when a child has a serious or chronic health problem: the mother pulls in closer to the ill child, taking time off from work or giving up her job to take the child to multiple appointments, be present during hospitalizations, supervise home care, and coordinate multiple health and school services. Her husband/partner keeps working, is not able to be as involved in their child’s care, and may even take a second job if the mother must give hers up. The family is under stress. Siblings fend for themselves. Over time, the mother becomes more comfortable with the child’s new needs. Through her high contact with the health care system and seeking information from additional sources, she becomes something of an expert on her child’s condition and learns to be his or her advocate. As mother and child pull closer together, father is often more and more distanced. The couple now has little time together. Their conversation is consumed by their child’s needs. The father is not up to speed on all the medications and treatments and begins to feel increasingly incompetent to care for his own child, so he pulls further away.

Knowing that this is a common scenario, we must “First do no harm.” All of us who work in pediatrics need to be aware of our potential to contribute to this pattern, which makes fathers feel excluded and inadequate, and to do everything we can to counteract it by showing respect to fathers, as well as to mothers and children. To act as if fathers’ opinions, feelings, and presence are unimportant is to disrespect them.

In my experience it is not so difficult to get fathers to come to an appointment with a psychologist, once we convey the message that we believe they are important and we need their help. They know things about their family that we don’t know. They have ideas, beliefs, and values that heavily influence how the family functions. And like every family member, they have deep feelings that may be difficult to express—love and caring, fear for their child’s future, anguish about not being able to do more to protect their loved ones from pain and sorrow, and, perhaps, scars of loss or harm from the past.

I have focused on fathers because we so often fail to include them in our work, naively accepting the mother’s account of them, thus setting ourselves up to fail (at which point we are tempted to fall into further error by joining the mother if she blames the father for the treatment failure), but this does not imply that other family members may not be of pivotal importance in our treatment. The maternal grandmother, for example, is a central figure in many families. If she lives in the household, it is absolutely imperative to include her. Depending upon the family structure she may be key even if she does not live in the same home.

The following example illustrates this point: A child was referred because of hair loss following the diagnosis of Type I diabetes. The endocrine team believed this was due to stress. Every family with a newly diagnosed child with diabetes is under exceptional stress. Major life changes are required to manage this illness, and it is always a significant adjustment for the entire family; however, most families are not referred for additional psychological services other than those routinely provided as part of the diabetes care. Something different was happening in this family. I met with the mother and child, the only persons living in the household. The father had left the picture years before. During the first part of our initial meeting, I probed and questioned but could not uncover anything unusual. I had no idea of what was going on with them.

When I don’t understand what is happening, I find it useful to change the lens to a larger systemic level. After first determining that there was no problem in the interaction with the health care team, I decided to enlarge the picture by dropping back a generation. I asked the mother about her own growing up. Gradually she revealed that she and her mother had a history of conflict around food. Eventually, she had become so avoidant that she did not enjoy eating and never prepared meals. With growing understanding, I asked who was doing her daughter’s food preparation. It turned out to be the maternal grandmother. Every morning, this mother dropped off her child at her mother’s home a few blocks away where grandmother prepared breakfast and a lunch to take to school. In the evening
mother and daughter ate fast food or cereal and milk. Had the mother told this to the diabetes team so that they could include the grandmother in the diabetes education? Certainly not. (Feelings of shame often play a major role in determining what information is shared with medical teams. For more on shame, see Fossum & Mason, 1986).

Now the picture had come into focus. With the permission of mother and daughter, I arranged to invite the dietitian from the diabetes team and the grandmother to our second session. The dietitian provided the grandmother with the necessary information on the child’s new dietary needs, and together, without making the mother feel inadequate for not preparing more of her child’s meals herself, we negotiated which adult would be responsible for which part of the child’s daily diet. The intervention was brief and effective because it was targeted. The mother no longer had an important secret to keep from the medical team. The child got better.

Another brief vignette will serve to illustrate the potential importance of siblings. The patient, an adolescent boy, was the youngest in a sibship of five in a family that had immigrated from a country in the Middle East a few years earlier. The parents had limited English language skills. Following major orthopedic surgery, there were difficulties with adherence to the physical therapy routine at home. The patient was oppositional and tearful when doing exercises and often refused them, and he exhibited significant anxiety and distress around wound care. The pediatric psychologist, who had formerly been an intern in our program, was consulted. In her initial assessment of the family, she determined that the two older sisters were the people in the family most able to be available to monitor the home care. She taught relaxation strategies and distraction techniques to the patient and his sisters and instructed them to use these during wound care, with both sisters to be present during dressing changes. For home physical therapy she arranged with the older sister living at home (age 20) to supervise daily exercises and report verbally to the other sister. A set time was established for physical therapy at home. The patient was given a choice of music to be played during this time. He was also given permission to make noise (e.g., grunt, cry, etc.) during physical therapy without reprimand from his sister. A behavioral plan was developed to be implemented by the sisters. A phone call one week later found that there was now satisfactory adherence to the regimen. Minor modifications were made to the plan based on feedback from the family. One-month follow-up in clinic found the plan was working well with significantly less anxiety exhibited and no difficulty with adherence to physical therapy exercises at home.

This intervention was successful because the clinician’s astute initial assessment of the whole family was able to determine who was actually available and most likely to be capable of carrying out the recommended interventions. In accordance with the Pareto Principle, she took the time and made the effort during the assessment phase to look for the family’s areas of strength, sorting the information that represented the “vital few” from the “trivial many.” Through her sophisticated gathering of a careful history that included all family members, she determined who within the family system could help the identified patient. Major changes could be accomplished because the intervention was appropriately targeted to identify the family’s competence and utilize it in the treatment plan. Meeting the whole family was of pivotal diagnostic significance in devising the right intervention.

Implications for Training Pediatric Psychologists

In closing, I would like to touch briefly on training issues. If we want to teach systems thinking, we must be mindful of the structural and systemic features of our training programs. If we want trainees to look for the best in families and build on their strengths, we must model this by our interactions with our students and colleagues. Hypocrisy undermines morale and shrivels the soul. Do supervisors have good relationships that model mutual collegial respect? Do they maintain clear and frequent communication so that they cannot be split? Is the program organized so that students are not put in impossible positions? Is ethical behavior modeled, practiced, and openly discussed at a programmatic level? Are relationships with other systems (e.g., medical) a regular focus of supervision? Are students encouraged to explore their family of origin issues so that they can better understand their own strengths and vulnerabilities?

As psychologists, we know very well that actions speak louder than words. Modeling is our most powerful tool for teaching. If we want students to learn to think systemically, we must be mindful of the systems of which we are a part. How well these
work must be on the agenda for open discussion and must be the subject of our continual scrutiny. Although we cannot always control the larger systems within which we operate, we can speak truthfully with trainees about self-care within various systemic contexts and about avoiding impossible work situations. We can model setting and maintaining appropriate boundaries. If we are in positions of power within training programs, we can refuse to allow our trainees to be abused by unrealistic work demands, or to neglect them because we are overwhelmed, ourselves. And everyone in a supervisory role can model strong cohesion within the parent level of the “training family” hierarchy by showing respect and support for colleagues, praising their successes publicly, and handling staff problems by addressing them clearly without shaming those concerned, rather than with avoidance and gossip.

One of the greatest challenges in modeling, as a parent or as a supervisor, is to strive daily to live as we believe. Because temptations abound and many of us are distracted by overwork, keeping ethical standards high in the many small everyday behaviors that ultimately constitute our character is not easy: honesty in word and deed; refusal to do careless harm; admission of error with apology; maintaining an authentic self; and genuine attention and concern for each human being in our environment. In such an atmosphere ethical violations will be rare, but if they occur, they must be dealt with swiftly, clearly, and firmly. Ethically murky areas should be explored and discussed at length.

Every supervisor can model respect for trainees by meeting with them faithfully as scheduled; listening seriously to their accounts of their experiences, thoughts, and feelings; reading their notes and reports with care; promptly attending to their concerns; and positively reinforcing what they do well, while providing an adequately warm and supportive context for self-examination and critical feedback. We can model our commitment to lifelong learning by being open about what we do not know and sharing our enthusiasm about learning something new.

Like competent parents in a well-run family, those responsible for training must constantly monitor how trainees are doing both cognitively and emotionally, being mindful of the impact of higher systemic levels (“outside” the training program “family”), as well as within the “family.” The professional work of pediatric psychologists is both intellectually demanding and emotionally challenging. Given this, attention to trainee anxiety is particularly important. Although the curvilinear relationship between anxiety/arousal and learning/performance is well known to psychologists (Anderson, 1994; Yerkes & Dodson, 1908), it appears that this principle is frequently ignored in training situations, in which students are so flooded with anxiety that they cannot learn or perform well. Most trainees are already more anxious than is useful for them; increasing their anxiety by providing inadequate structure and support only interferes with their learning and decreases the likelihood that they will be helpful to patients.

Ultimately, the only tool we have is our own selves. We have a responsibility to create training programs that show each student respect and caring, creating a safe, trustworthy learning environment in which to challenge and develop that self. If our training programs are organized and run like a healthy family, with attention to consonance between values, structure, process, and outcome, our trainees will be able to learn from the past, live in the present, and move with confidence into the future, free to focus their lens on whatever systemic levels are appropriate. Having been supported to work within the complex realities of a multisystemic perspective, they will find themselves rediscovering, over and over again, the importance of the family in the practice of pediatric psychology.

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