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The Importance of Psychosocial Care in Pediatrics

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Regardless of ideological, political, economic and social differences between countries and cultures, medico-social problems and their modes of solution are remarkably similar.[2] Comparative epidemiological studies have shown that although there may be differences in the incidence of certain disorders of human biology and social living, the essential problems of human development, adjustment and pathology in different cultures and social milieux have many common aspects.

Progress in medicine has created new medical and social problems and has led to a need for self-appraisal and a new form of focusing on further individual and societal needs. For instance, the population of aged people has significantly increased in modern societies, through direct and indirect effects of progress in medical care, leading to the rise of a new and vast branch of medicine called *geriatrics*. Similarly, psychiatric problems have attracted increasing attention and efforts. Less developed countries or traditional societies, however, have not yet overcome many common problems of preventive medicine and pediatric care and have not yet reached a level which requires them to focus sufficiently on these new problem areas.

It is a known fact that many classical therapeutic institutions (children's homes, nurseries, orphanages, hospitals, institutions for the care and rehabilitation of retarded and handicapped children, etc.) have already been outmoded.[11, 16] This is because the most modern therapeutic institutions have not been able to cope with the growing demands of society, which include not only prevention, dissemination of services to remote areas, continuity of care, follow-up, etc., but also knowledge

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and management of many psychosocial problems. The so-called comprehensive or total health care practices are as yet abortive endeavors to meet the growing needs of ever changing psychosocial and physical environment. In countries said to have the most advanced and well planned welfare states, with the best organized health services in the world and with minimum private practice (e.g. Sweden and England), the principal criticism that the public makes of the health care system is that it is inhumane, bureaucratic, slow and offers no freedom of choice.[11] On the other hand, in many less developed countries, therapeutic institutions and practices, the models of which have been mainly taken from the Western world, have left many problems unsolved and difficult to approach. Problems of malnutrition, infection, sanitation and many diverse problems of child care can be cited.

As medicine has succeeded in broadening its areas of intervention with increasing effectiveness, the expectations of society from the medical profession and its related institutions have been growing accordingly. For example, successful treatment of a child with malnutrition immediately requires looking into the psychosocial environment in which the child has been reared. Another example to clarify our point may be the dramatic development of transplant surgery, which on the one hand has saved lives but which has also caused many legal and psychological problems not adequately predicted or recognized. A recent and as yet uncompleted study[8] of this issue at the Hacettepe University Medical School in Ankara reveals that families can be seriously disrupted or individuals depressed by a request for a suitable live donor for kidney transplant. These issues create a new problem related to the identity of the medical profession. The crucial question is probably a redefinition of medical care, not solely in terms of a traditional medical model, but also in terms of a psychosocial frame of reference. Without being adequately cognizant of its own boundaries of identity and responsibility, the modern medical profession is in direct and inevitable involvement with psychosocial problems, and because of its traditional outlook it is in a conflict in redefining its own identity. Gradual recognition of the shortcomings of medical practice and of societal dissatisfaction, however, has made the development of a psychosocial model of human care inevitable and absolutely necessary.

Psychosocial concepts in human care have been known and defined in various ways since ancient times. For example, the following statements of Avicenna[1] reflect the depth of his intuitive insight and knowledge as the psychosocial aspect of human development and health:

> Children should be carefully attended and supervised regarding their behavior so that they do not exceed the limits of moderation. Outbursts of violent anger, fear and anxiety should be checked. This is best ensured by considering the child's natural desires and inclinations, and keeping in view his aversions. The natural aptitudes of the child should be encouraged while the causes of irritation removed. This type of training is good for body and mind both. The mind is benefited because good habits and manners are permanently ingrained in the personality by early training.... When the child is six years old he should be sent to a teacher for education and training. Care should be taken to adopt a progressive system and not burden the child with books all at once....

A deliberate and conscious discussion and critique of the medical model, however, is rather recent. The reasons for this may lie in the processes of professionalization, specialization, monopolization and dehumanization of medical care and of institutions, particularly during the last century. These processes have led to an alienation of the medical profession and its services in relation to society, and a serious gap between the medical profession and the societal institutions has come about. The services of medicine now seem to be so important to society that it will no longer tolerate that the delivery of medical care be left primarily in the hands of the profession. In these new situations medicine has once again to lead the way and to discover how to satisfy the conflicting demands of society and the profession.[11]

Thus a psychosocial model of medicine is simply an elementary and holistic approach to the human being in his total psycho-biological, physical and social milieu.

The Family as a Psychosocial Care System

The simplest and primary psychosocial care system is undoubtedly the family, with all its biological, genetic, individual and social aspects. Modern society is faced with the great problem of rapid changes in the family system, which have led to the establishment of many extra-familial institutions. In modern societies, there are institutions besides the family which are indispensable in rearing children, i.e. nurseries, kindergartens, religious institutions, youth centers, etc., and there are also therapeutic or preventive organizations, to secure and maintain good health. In countries where adequate or superior socio-economic development has been achieved, these institutions have drawn the in-

terest of the state and individuals or groups to the extent that responsibilities have shifted considerably from the family. In those societies where the individual is usually expected to move away from his nuclear family as soon as possible, and where he is encouraged to develop a high sense of self-reliance, autonomy and initiative, it is understandable that the main diagnostic and therapeutic focus would be more on the individual than on the family. The disadvantages of such a system in the forms of over-professionalization, specialization and dehumanization processes have already been mentioned.

In a less developed country like Turkey, where modern, transitional and traditional segments of society are still present, neither is the child's independence from the family encouraged as much as it is in the Western world nor are extra-family (i.e. state or community) supports of personality development and health sufficiently established and distributed. Therefore, the structure and dynamics of family life, role and responsibility patterns and the interdependence of family members, as well as rapid changes, must have a special significance for any health officer in such a country.[14] Although this appears on the surface to be a disadvantageous situation for the less developed countries, the industrialized affluent societies have recently recognized the neglect of the family as a psychosocial care system and have realized the need for a reconsideration of the family as a whole; hence the concepts of the family physician, family medicine and family therapy have been revived.

The lineal and collateral family ties in the traditional or less developed societies can be used as sources of strength in a psychosocial care system. This can be actualized in the form of easy availability of the families for children or for aged people in need of care and protection. The alternative in industrialized societies is institutionalization, the disastrous effects of which are already well known from studies on maternal deprivation, hospitalism, juvenile delinquency and drug abuse.[3, 4, 9, 10, 17, 18] The unfortunate trend of taking the traditional Western medical model and adopting its institutions in the less developed countries will probably be too costly in a psychosocial sense as well as economically.

It is quite frequently observed that, particularly in rapidly developing countries, a different form of cultural gap grows up between the educated physician and his less educated society, thus leading to defective communication between the medical profession and the patient and his family.[11] To a lesser extent this gap exists in modern societies also.

Considering such problems as crucial for the well being of society, our medical school at Hacettepe University in Ankara, established in

1963, organized its entire teaching program into an integrated system.[5] In the Department of Community Medicine, through the collaboration of pediatricians, psychiatrists and child psychiatrists, public health workers, psychologists and sociologists, a family oriented approach was taken as a main goal of teaching and practice. By assigning each first year medical student to a family from a low socio-economic level, the student studies the social and psychological problems of the Turkish family. A course in child development, with biological and psychosocial content, has been an integral part of the teaching of community medicine, as as well as of pediatrics and psychiatry. During this clerkship period the student also rotates in the specially designed rural health centers, where he has ample opportunity to study the traditional family and its problems in vivo. In these rural health centers and in their base hospitals, psychiatrists and child psychiatrists work together with the primary care physician both in patient and family care and in training. With this form of training and practice the primary care physician becomes more aware of the problems of child rearing, value systems, resistances to treatment or preventive measures, the role of the woman in the society, and other social and economics issues, and therefore recognizes the acute need for integration of a psychosocial model within the medical system.

Intramurally, within the university hospital setting, similar programs, particularly directed to a psychosocial understanding of the child and his family, have been of dramatic usefulness. To illustrate this point one example will be given. A group of nurses in a pediatric ward at Hacettepe met regularly with a group of psychiatrists to discuss certain problems of children in need of surgical or medical intervention. The children's fears and resistance to the processes of medical or surgical intervention, and their anxieties of separation from their families decreased dramatically as the nurses developed a psychosocial skill in their approach, but at the same time this created some resistance on the part of the physicians, whose identities as the monopolizing responsible figures were somewhat threatened. These problems were subsequently resolved in a similar way.[19]

Space does not permit our elaborating on all the areas of a psychosocial model of care. We would like, however, to stress two basic issues. One is the doctor-patient relationship, which is the sine qua non requisite of a psychosocial approach. From time immemorial the most important therapeutic tool in medicine has been the doctor-patient relationship, which includes not only a dyadic relationship but a transaction with the whole family as well as with the society at large. Cultural characteristics of doctor-patient relationships, peculiarities of value orientation

systems,[12] attitudes and expectations have to be recognized adequately. While in one society a highly passive, dependent and magical expectation from the physician and a total submission to his authority may be the prevailing mode of patient attitude, in other societies mutual inter-action and responsibility-taking between patient and doctor may be more important.

The other basic issue is concerned with the evaluation and interpretation of significant childhood experiences (including childhood traumas and illnesses) in terms of our knowledge of psychodynamics and of psychosexual development. While pediatricians have generally adhered to a more or less biological and maturational aspect of child development, the impact of the psychoanalytical psychosexual theory of development has not been insignificant. The following excerpt from a study carried out in Turkey[14, 15] will shed light on the controversial aspect of this impact, and we quote: "European and American psychiatrists and pediatricians are stunned when they learn of the tradition of the circumcision of children without anesthesia commonly performed between the ages of four and eight. Their reaction is certainly related to the influence of the psychoanalytic psychosexual theory which dominates most textbook chapters on personality development. Can we consider such an experience during a specific period of development, let us say in pscychoanalytic terms the phallic stage, as being utterly traumatic? The study has shown that the trauma effect is not so directly related to the circumcision itself, or to the specific stage of psychosexual development, as to the concurrent familial and societal events which actually provide the essential meaning of the experience. The operation which initially arouses intense fears and avoidance reactions and is there fore potentially traumatic gradually becomes through social approbation and reward, an experience strongly needed by the ego, so much so that the *lack* of it may be severely traumatic. It is suggested that psychosexual specificity of childhood experiences needs to be evaluated in a psychosocial context."

With this example we would like to conclude that human development needs to be viewed in a broader theoretical frame than those offered by certain pediatricians (as Gesell), by certain psychologists (as H. Werner, Piaget), by psychoanalysts (Freud), and other schools. The more recent psychosocial epigenetic developmental theory of Erikson[6, 7] who has tried to bridge the gaps between individual biological and psychological development theories and those of societal processes, can offer

us new insights in providing a psychosocial care model that is in vital need of being integrated into the medical profession as well as into educational institutions.

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