

Child-Witnessed Domestic Violence

According to the Family Violence Prevention Fund, domestic violence is a “pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners in current or former dating, married or cohabitating relationships of heterosexuals, gay men and lesbians. The purpose of this violence is to achieve compliance from and control over the victim.” While domestic violence is directed at an intimate partner, when children are present, they too become victims. In fact, it is estimated that more than 3 million children each year are exposed to parental violence.

reprinted with permission: Groves BM, Zuckerman B, Marans S and Cohen DJ. "Silent victims - children who witness violence." JAMA January 13, 1993, Vol 269, No. 2, p. 262-264.

Impact on Children's Development

Exposure to violence adversely affects children's development in many areas, including their ability to function in school, emotional stability and orientation towards the future. These effects may be long lasting. The severity of a child's reactions to trauma is related to the proximity to the violent event, the victim's relationship with the child and the presence of a parent or caretaker to mediate the intensity of the event. Children who have been exposed to violence may also display symptoms associated with posttraumatic stress disorder, such as diminished ability to concentrate in school, persistent sleep disturbances, flashbacks, disordered attachment behaviors with significant caretakers, sudden startling and hypervigilance, and a nihilistic, fatalistic orientation to the future, which leads to increased risk-taking behaviors.

Most studies on the effects of traumatic exposure to violence on children have focused on elementary-school-aged children and adolescents. Preliminary evidence, however, suggests that preschoolers may be especially vulnerable to the effects of traumatic exposure to violence. Witnessing relatives and friends being hurt in fights or shootouts is especially stressful for young children who are already struggling with developmentally appropriate concerns about safety, competence, and bodily integrity. The young child's attempts to master the age-appropriate fears of monsters under the bed are severely undermined when the child needs to sleep under the bed to dodge real bullets or attempt to screen out the violent fights of his or her caregivers. During the early years, children turn to their parents as the most immediate source of stability, control and protection. When these same adults are the wounded victims, out-of-control combatants, or emotionally distraught casualties of violence, the world of the young child is no longer safe or stable. The calm, reassuring voice of the parent has little currency or is absent when parents themselves are frightened and insecure. Young children who have witnessed violence bear the additional burden of being least able to communicate their fears and reactions in words. Perhaps because of an inability to understand the language of young children, adults may have a tendency to deny the serious impact that witnessing violence will have on development, assuming - or wishing - that young children will not understand and will forget what they have seen.

Children who witness domestic violence may be particularly vulnerable to emotional and developmental problems. Studies have not yet been conducted to compare the range, type and severity of problems between children who witness violence in the home with those who witness it outside the home. However, based on our clinical experience, it appears that witnessing violence between parents in the home results in more severe consequences. Data are available

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showing that children who witness violence in the home identify along gender lines with their parents' relationship. Boys become more abusive as adults; girls become victims. Children of both sexes may come to see violence as an appropriate means of resolving conflict and as an integral part of a close relationship.

reprinted from the Statistics Packet: 3rd Edition. National Clearinghouse for the Defense of Battered Women. February, 1994.

How many children witness violence towards their mothers?

- It is estimated that family violence is prevalent in 3 to 4 million American homes (Jaffe, 1990). Approximately 3.3 million children ages 3 - 17 witness their parents' interpersonal violence each year (Carlson, 1984).
- Retrospective accounts from women in shelters reveal that as many as 80% of the women recall witnessing their mother being assaulted by their father as well as being assaulted themselves (Jaffe, 1990).

Psychological and social trauma caused by witnessing abuse

- Children in violent homes face dual threats: the threat of witnessing traumatic events and the threat of physical assault. Children of abused women can be injured during an incident of parental violence; be traumatized by fear for their mother and their own helplessness in protecting her; blame themselves for not preventing the violence or for causing it; or be abused or neglected themselves (Gaylord, 1975).
- Jaffe found that children who have chronically witnessed abuse have similar reactions to children who have been physically abused: "disruptions of normal developmental patterns that result in disturbed patterns of cognitive, emotional, and/or behavioral adjustment...Infants who witness violence are often characterized by poor health, poor sleeping habits, and excessive screaming" (NOMAS, 1993).

- Among preschoolers, Davidson, Alessi and Hearn found signs of terror, as evidenced by the children's yelling, irritable behavior, hiding, shaking and stuttering. They often experienced insomnia, sleepwalking, nightmares, and bed wetting. They suffered psychosomatic problems such as headaches, stomach aches, diarrhea, ulcers, asthma, as well as regression to earlier stages of development (NOMAS, 1993).
- Adolescent boys exposed to domestic violence may use aggression as a predominant form of problem solving, may project blame onto others, and may exhibit a high degree of anxiety. Girls are more likely to display withdrawn, passive, clinging and dependent behavior (NOMAS, 1993).
- Children exposed to wife abuse often have difficulties with school, including poor academic performance, school phobia and difficulties in concentration. They are constantly fighting with peers, rebelling against instruction and authority, and are unwilling to do school work (NOMAS, 1993).
- Many children suffer low self-esteem, sadness, depression, stress disorders, poor impulse control, and feelings of powerlessness, and they are at high risk for alcohol and drug use, sexual acting out, running away, isolation, loneliness, fear and suicide (Jaffe, 1990).
- Hughes reported that 22% of children residing in shelters were characterized as very withdrawn and 10% were described as having made suicidal gestures. The children showed signs of restlessness and nervousness, confusion because of the differences between home and school environments, reticence in discussing violence, and fantasies about a different home life. Similarly, Alessi and Hearn reported that a sample of children in a shelter for battered women often exhibited a high degree of anxiety, such as biting fingernails, pulling their hair, somatic complaints of headaches and "tight" stomach aches (Jaffe, 1990).
- Various studies have catalogued serious behavioral and emotional consequences of living in a violent home. For example,

Gaylord and others described a range of children's reactions that included enuresis, stealing, temper tantrums, truancy, violence toward others, insomnia, anxiety, tics and the presence of fears and phobias. Hilberman and Munson were the first to describe a developmental pattern for child witnesses. Characteristic problems of pre- and elementary-school children included psychosomatic complaints, school phobias, enuresis, and insomnia. Older children showed sex-specific reactions. Boys typically engaged in aggressive, disruptive behavior while girls were reported to have difficulty concentrating on schoolwork. In other studies, adolescents, particularly females, were noted to suffer from feelings of worthlessness, depression, negative attitudes toward marriage, and distrust of intimate relationships. Male adolescents were reported to view the use of force as a legitimate means of solving interpersonal conflict. They were also found to be vulnerable to behaving violently toward their girlfriends and at times toward their mothers (Goodman, 1987).

- In a study of 2 ½ to 8 year old child witnesses to spousal violence, Westra and Martin found preliminary evidence of decreased cognitive abilities and poor school performance relative to the children's age norms (Goodman, 1987).

Does Witnessing Abuse Create Future Abusers and Future Abused?

women

- Battering was reported to have been present in 67% of the battered women's childhood homes, 81% of the batterers, and only 24% of the non-batterers' (Walker, 1984).
- In a community sample of battered women who were not residing in crisis shelters, almost one-third indicated that they had witnessed violence and had been abused themselves (Jaffe, 1990).
- When Stark and Flitcraft (1985) compared the pediatric records of battered and nonbattered women, they found that the abuse victims had an excess risk of

childhood abuse 14 times higher than expected (15% vs. 1%).

- Studies of battered women indicate that a high percentage have come from abusive homes. Research on incest victims also points to a strong tendency for these individuals to be become involved in battering or other assaultive relationships as adults. Herman has hypothesized that a history of child sexual or physical abuse, or witnessing the abuse of others in the home, may have the effect of making a woman less skilled at resisting abusive behavior and more apt to accept victimization as a part of the expected interactions of a family (Browne).

men

- Studies show that boys who witness their father beating their mother are three times more likely to abuse their own wives. Sons of the most violent families have a wife beating rate that is 1000 times higher than sons of non-violent parents (Strauss, 1980).
- In a study of men in a Washington State abusers' program, 63% had either experienced physical abuse or had witnessed physical abuse involving their parents when they were children (Ganley, 1988).
- A Baltimore City study in 1983 found that 75% of men seen in a batterers program reported witnessing their fathers beat their mothers; 50% reported being abused as children (Family Violence Coalition, 1991).
- Kaufman and Zigler in a 1987 comprehensive review of the literature on intergenerational transmission of violence, estimated the rate of intergenerational transmission to be 30%, plus or minus 5%. Their finding suggests that approximately one-third of those who have suffered physical or sexual abuse or neglect as a child will subject their own children to some form of abuse, two-thirds will not (Wofford, 1992).
- The two greatest risk factors for a man to batter a woman are having witnessed his own father batter his mother, or having himself been abused during childhood (Hotelling, 1986).

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- The people who experienced the most punishment as teenagers have a rate of wife-beating and husband-beating that is four times greater than those whose parents did not hit them (Strauss, 1980).
- Almost 82% of the husbands who witnessed parental spouse abuse were also victims of child abuse at the hands of one or both parents (Rosenbaum, 1981).

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Childhood and Adolescent Substance Abuse

excerpts reprinted with permission: Petersen RC. Childhood and Adolescent Drug Abuse: A Physician's Guide to Office Practice, Washington, DC: American Council for Drug Education, 1987.

Substance Use, Abuse and Dependence: Detection, Diagnosis, and Referral

You are undoubtedly aware that substance use involves millions of children, adolescents and young adults, most of whom began smoking, drinking and using other psychoactive drugs in late childhood and adolescence. While the very high rates of daily marijuana use of the late 70s have diminished, this is no basis for complacency. Substance use leading to serious behavioral or health problems is still all too common and the level of drug use in the United States is still higher than that in any other industrialized society. By the time they are high school seniors, most adolescents have tried alcohol, tobacco and marijuana and many smoke cigarettes daily.

the physician's role

As a physician, you are the medical confidant and health authority for many children, adolescents and their parents during a critical period when the foundation is being laid for lifelong health habits - including the use of alcohol and other drugs. Your ability to recognize that some of your patients may have a drug-related health or behavioral problem, or the potential for developing one, is important.

the changing drug scene

The "drug scene" is rapidly changing. It is not the one you may remember from your college or medical school years. Cocaine is now used by far more people, including adolescents, in much more hazardous ways (eg, smoking crack). There is also a much larger body of research indicating that drug use which was once believed to pose

little risk (eg, marijuana and cocaine) is in reality hazardous, especially for the young.

usage patterns

For this reason, the terminology describing alcohol and other drug use has been changed. To better reflect our understanding about the variations that occur in usage patterns, we now talk about a continuum that includes substance use, substance abuse and dependence.

- **Substance use:** Use refers to the sporadic use of drugs and alcohol. In addition to progressing to abuse, substance use can also result in such other serious problems as accidents, exposure to HIV and psychiatric effects.
- **Substance abuse and dependence:** Substance abuse and dependence are more severe forms of substance use and are classified as medical conditions. Both usually require specialized treatment.

"high risk" children

While virtually all children have the potential for becoming substance abusers, we now know that some youngsters are at much greater risk of becoming seriously involved than others. Identifying these "high risk" children early may help to avert their developing substance abuse problems. Alerting your young patients and their parents to the possibility of developing problems may deter or delay substance use and make early detection more likely.

risk factors for substance use, abuse and dependence

Both animal and human research provide evidence that abused substances derive their dependency producing properties from their reinforcing effects on the Central Nervous System. If a dependence producing substance is taken often enough and in large enough quantities, most people will become dependent on it. However, there are also large individual

differences in susceptibility to the development of a substance use disorder.

Behavioral Signs of Substance Use, Abuse and Dependence

A combination of the following signs should alert you to the possibility that a patient is using illicit substances and to the importance of exploring that possibility through an interview and/or laboratory testing:

1. Sudden decline in school achievement. Since alcohol and other types of drug intoxication interfere with learning, it is not surprising that rapidly deteriorating school performance frequently results. Poor functioning in school which contrasts sharply with earlier adequate functioning, especially in the absence of a school change or other obvious explanation, should arouse suspicion.
2. Cigarette smoking.
3. Marked shift in the child's peer reference group, especially association with known or suspected drug users.
4. Serious erosion of parental trust in the child.
5. Support by the child for the idea of legalizing marijuana.
6. Marked personality changes. Although childhood and especially adolescence are often marked by mood swings and some instability, evidence of social withdrawal, marked changes in openness to communication with other family members, inexplicable depression or other evidence of psychological disruption such as changes in sleeping, are all possible indicators of drug involvement.
7. Withdrawal from extracurricular activities that were previously important to the child, such as athletics, religious or youth programs, band, etc.
8. "Cutting" classes, tardiness or truancy from school.
9. Deterioration in appearance and personal hygiene.
10. Increased secretiveness, unexplained phone calls, heightened hostility to inquiry, sudden onset of hypersensitivity.

11. "Going out every night." Youngsters who are intensely involved with weekday social activity consisting primarily of "hanging around" (as opposed to scheduled youth activities or activities on weekends) may be drug involved.
12. Unexplained disappearance of family funds, or family and personal possessions (this may be related to obtaining money for drug purchase).
13. Aggressive behavior such as recurrent fighting, violent hostility, or other evidence of social alienation.
14. Heavy use of over-the-counter preparations to reduce eye reddening (e.g., injected conjunctiva produced by acute marijuana intoxication) or the nasal irritation (resulting from "snorting" cocaine) or tell-tale bad breath (produced by alcohol or cigarettes).

physical symptoms of alcohol and other drug use

Behavioral manifestations, not physical appearance, are the red flags of alcohol and other drug use. Generally, physical symptoms or sequelae of substance abuse will not be obvious. For example, smoking marijuana or crack cocaine may not usually cause coughing, wheezing, or other obvious irritation of the upper respiratory system. While a reddening of the eyes often occurs, eye irritation can have a variety of other causes, so this symptom is hardly pathognomonic. Even acute intoxication with marijuana may not be apparent. Many experienced marijuana users are able to hide the outward signs of the drug's intoxicating effects, thereby disguising their use and fooling even the most astute physicians.

Although some clinicians have noted a quality of listlessness, unhealthy pallor and complaints of tiredness in their young, drug using patients, these symptoms may not always be apparent even in advanced stages of use. While weight loss and other evidence of malnutrition may occur following continued use of cocaine or other stimulant drugs, they are unlikely to result from recent or occasional use.

- **Evidence of I.V. drug use:** Given the risks of such secondary infections as hepatitis and AIDS, and of anaphylactic reaction to

the injected material, any evidence or admission of I.V. drug use should be regarded as indicating a need for assessment by an experienced drug treatment professional.

interview techniques

Your knowledge about your patient's development and your continuing rapport with them are probably your most powerful tools in preventing and diagnosing substance use, abuse and dependence. Since alcohol and other drugs are not used *in vacuo*, your knowledge about individual children, how they are getting along with their families, their teachers, and their peers is invaluable.

- **Behavioral Signals:** Behavioral changes or problems that have developed since a child's last visit are often evident after even brief interviews with the patient and parent. Usually, children who are involved with alcohol and other drugs send out behavioral signals and frequently such changes or problems will emerge during the routine questioning you undertake as part of your examination.

confidentiality

Your role as child or adolescent health care provider should be to advocate for the best health possible for patients and their families. As an advocate, you will need to make decisions when to involve parents in the care of your adolescent and young adult patients. Adolescents have the legal right to receive confidential services regarding substance abuse, mental health and reproductive health care. Some patients may be sufficiently involved in substance abuse or other risky behaviors that involvement of their parents may be appropriate. Making decisions regarding when to involve parents requires an individual sensitivity to the specific behaviors, associated health problems and willingness of that patient to work with the provider.

For those patients who are sufficiently involved in severe or health threatening behavior and who express an unwillingness to appropriately work with the provider at improving their health care behavior, parental involvement is necessary. Before taking any action, however, the health provider should inform the patient of his or her

concerns and intention to involve the parents. Since drug users at every age frequently deny that their functioning has been affected even when the impairment is obvious, there is the distinct possibility that your position on disclosure will class you with other adults as an adversary. This is a risk that must be taken in the long-term interests of your patient's well being and to fulfill your professional role.

using opportunities to discuss substance use

The amount of time you can spend with any patient is very limited, but even that required for a routine physical examination can explore possible substance use and encourage a drug-free style. The routine chest examination provides an excellent opportunity to ask about cigarette smoking and marijuana use. Since the youngster may believe that you can detect use of these substances by your chest auscultation, he or she will usually respond openly to direct, but nonjudgmental inquiry. Routinely asking about alcohol use in the child's school and among his or her peers readily leads to questions about personal use. This questioning is likely to be non-threatening to your patient in the context of your concern with his or her overall health and well-being.

patient reactions to your questions

An important clue to more serious involvement with substance abuse is marked defensiveness about use or any kind of emotional response to your routine questions. If this reaction occurs, it provides a further basis for inquiry, pointing out to the patient that the topic seems to be a sensitive one and you wonder why.

parent/patient sessions

Some physicians who provide primary care to children have found that scheduling family sessions from time to time in which the parent(s) can discuss their child's health and any other problems in child rearing they are experiencing, can be important in building a professional relationship with them and with their child. It also helps to communicate your desire to encourage their child's healthy development in any way you can. Such conferences can be useful at 6 weeks after birth, about age 2, just before the child enters school, before adolescence, during the high school years and possibly just

after high school graduation. They can provide an opportunity for an unhurried discussion of child health issues, including the need to develop a firm parental stance against the use of alcohol and other drug use. Knowing that you are available for a longer conference on a regular basis (if one is needed) may also make the parent (and your patient) more willing to bring up problems that cannot be adequately dealt with in a brief routine visit.

Discussing the Findings with Patient and Parent

Should the interview and/or the laboratory testing give evidence of drug use, the nature and extent of the child's involvement must be explored. If other behavioral signs of drug involvement are present, the test results provide objective confirmation that drug abuse is a central problem.

why is the patient using drugs?

The drug use may be the patient's way of self-medicating anxiety or dealing with problems in living or a lack of self-esteem. But even though drugs may temporarily alleviate some of these feelings, substance abuse is destructive to emotional maturation and other aspects of growth and development. Thus, objective confirmation can sometimes be a relief to all concerned, making it easier for both the youngster and the parent(s) to acknowledge that a problem requiring their attention exists.

how to respond to isolated or minimal use

- **what to say**

If use has, in fact, been relatively isolated, the child may find evidence of your concern reassuring of adult love, especially if the use is not moralistically condemned, but treated as a potential health hazard. Avoiding a moralistic stance without in any way condoning use is important.

- **the alcohol argument:** Young people are sometimes very indignant that adult use of alcohol or tobacco is socially acceptable, but their drug use is not. Emphasizing that abuse of all drugs (including alcohol) is a serious medical and social problem and that your concern is with the health and

development hazards, regardless of the drug's legal status or social acceptability, may help to defuse that argument.

- **the intoxication issue:** Making the point that intoxication with any substance is undesirable at any age and especially while undergoing marked developmental changes and acquiring the necessary skills for adult life, may also be useful since using marijuana is a form of intoxication more analogous to getting drunk, the argument that the adolescent's "joint" is like the adult's before dinner cocktail loses much of its force.
- **the health and developmental implications of use:** Frank acknowledgment of the seriousness of adult alcohol and other drug use (including that of tobacco) can make it clear that you are not advocating a double standard. You should make clear to your patient that your concern is with the health (and developmental) implications of use. Moreover, just as there is good reason to be particularly concerned about diet and other health habits during pregnancy, there are equally good reasons for concern about behavior that can potentially interfere with healthy childhood or adolescent development. Fortunately, the recent decline in drug use by adolescents has also been accompanied by an increased disapproval of these drugs by young people themselves.
- **what to do:** If drug use has been minimal and very few risk factors exist, the early identification of use, the involvement of parents, and your expression of concern can be enormously helpful in enabling the child to become and remain drug free. Continued inquiry and follow-up testing on subsequent examinations can provide some assurance that good health habits are continuing.

Summary

Your capacity to detect signs of possible alcohol and drug use, share your concerns with your patients and their parents, initiate sound referrals for assessment, and support any treatment that may be recommended can have a lifelong positive impact on your patient's health and well-being.

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"The four core skills - active listening, soliciting attribution, providing support and establishing agreement - are at the heart of the model of co-participation between physician and patient. Used effectively, they provide a mutually satisfying environment in which psychosocial as well as biologic aspects of a problem can be explored in a humane, caring and surprisingly efficient way."

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included the following: 23 (46%) had used alcoholic beverages (10 at age less than or equal to 13 years), 17 (34%) had experience with marijuana, four (8%) had used other psychoactive drugs, and 14 (28%) were having sexual intercourse, while only eight were using contraception. This study suggests the usefulness of a questionnaire to identify individual health care needs for which preventive counseling may be offered."

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behavior, body image, home life, and mental health. Using three-factor repeated measures ANOVA, significant differences were found primarily in the psychosocial category and chief complaint question. Findings suggest that many adolescents are reliable informants about their medical histories, but private interviewing of the teenager may be necessary to determine high-risk behaviors."

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translator, avoiding persons who are linguistically incompetent, culturally insensitive, and medically unsophisticated. Physicians also should avoid assuming that parents who "speak English" are fluent. A determination of their language preference and their degree of English proficiency may lead the pediatrician to use a translator even with partially fluent families."

Horwitz SM, Leaf PJ, Leventhal JM, Forsyth B, Speechley KN. "Identification and management of psychosocial and developmental problems in community-based, primary care pediatric practices" *Pediatrics* 89(3): 480-485, March 1992.

"The goal of this research was to refocus interest on the problems of the new morbidity. This study examined the rates and predictors of psychological problems in 19 of 23 randomly chosen pediatric practices in the greater New Haven area. Families of all 4- to 8-year-old children were invited to participate and to complete the Child Behavior Checklist prior to seeing a clinician. Clinicians completed a 13-category checklist of psychosocial and developmental problems based on a World Health Organization-sponsored primary care, child-oriented classification system. Of the 2006 eligible families, 1886 (94%) participated. Clinicians identified at least one psychosocial or developmental problem in 515 children (27.3%). Thirty-one percent of the children with problems received no active intervention, 40% received intervention by the clinician, and 16% were referred to specialty services. Not surprisingly, children whose problems were rated as moderate or severe were twice as likely to be referred compared with children with mild problems. Recognition of a problem was related to four characteristics: if the visit was for well child rather than acute care; if the clinician felt he or she knew a child well; if the child was male; and if the child had unmarried parents."

Howard BJ. "The referral role of pediatricians" *Pediatric Clinics of North America* 42(1): 103-118, February, 1995.

"Pediatricians have a vital role in making effective mental health referrals for many

children and their families. After selecting families who are appropriate for referral, for which type of resource, and the severity of their problems, the clinician should carry out a careful process to ensure the success of the referral. Special attention should be paid to finding the pain in individual family members, locating appropriate resources, and following up once a referral has been made.”

Jellinek M, Little M, Murphy JM, Pagano M. “The pediatric symptom checklist. Support for a role in a managed care environment” *Archives of Pediatric and Adolescent Medicine* 149(7): 740-746, July 1995.

“The purpose of this study was to gather data based on studies of the Pediatric Symptom Checklist, identify risk factors associated with high levels of dysfunction in primary care pediatric settings, and explore the relationship between common risk factors and psychosocial problems identified by pediatricians. Children with a single parent and/or those who were economically disadvantaged were significantly more likely to show psychosocial impairment. The specificity of the Pediatric Symptom Checklist was 100% in samples with a lower socioeconomic status compared with 68% in middle-class samples, and sensitivity was 95% in middle-class samples compared with 80% in lower-class samples. Pediatricians identified psychosocial problems in eight of 15 children with a history of familial mental illness or substance abuse and seven of eight children with a history of physical or sexual abuse, but only six of 17 cases from single-parent families and four of 11 cases from poor families.”

Levinson W, Stiles WB, Inui TS, Engle R “Physician frustration in communication with patients” *Medical Care* 31(4): 285-295, April 1993.

“In this study, the nature of practicing physicians' 'frustrating' visits was explored and a guide to help physicians identify problems in communicating with patients was developed. The study included 1,076 practicing physicians who attended a voluntary workshop on physician-patient communication. The method included

development of a preliminary item pool (descriptions of frustrating patients and occasions) by experienced physicians and teachers of medical communication, additions/deletions/revisions of items within the pool, empirical analyses to reduce redundancy and group-like items, and construct validation of the final 25-item questionnaire. Factor analysis was used to identify subscales. Physicians most often attributed communication problems to the patient rather than to their own limitations. Seven types of communication problems (subscales) were identified, including: 1) lack of trust/agreement, 2) too many problems, 3) feeling distressed, 4) lack of understanding, 5) lack of adherence, 6) demanding/controlling patient, and 7) special problems. Primary care physicians reported greater problems than specialists on four subscales. Physicians practicing in health maintenance organizations reported greater problems than physicians in fee-for-service practice on five subscales. Seven sources of frustration physicians experience in their work with patients were identified.”

Levinson W, Roter D. “Physicians' psychosocial beliefs correlate with their patient communication skills” *Journal of General Internal Medicine* 10(7): 375-379, July 1995.

“The purpose of this research was to assess the relationship between physicians' beliefs about the psychosocial aspects of patient care and their routine communication with patients. The data showed that physicians' attitudes toward psychosocial aspects of care were associated with both physician and patient dialogue in visits. The physicians who had positive attitudes used more statements of emotion (ie, empathy, reassurance) and fewer closed-ended questions than did their colleagues who had less positive attitudes. The patients of the physicians who had positive attitudes more actively participated in care (ie, expressing opinions, asking questions), and these physicians provided relatively more psychosocial and less biomedical information.”

PANDORA'S BOX

Levy DR. "White doctors and black patients: influence of race on the doctor-patient relationship" *Pediatrics* 75(4): 639-643, April 1985.

"Effective communication between doctor and patient, a skill not emphasized in medical education programs, is essential for patient satisfaction and optimal patient care. In many teaching hospitals, the doctor is commonly white and middle class and the patient black and indigent. Racial differences, even in the absence of social class differences, may have a negative impact on the quality of the doctor-patient relationship. The impact of racism is reviewed and recommendations to enhance the relationship between white doctors and black patients are made."

Lynch TR, Wildman BG, Smucker WD. "Parental disclosure of child psychosocial concerns: relationship to physician identification and management" *Journal of Family Practice* 44(3): 273-280, March 1997.

"The purpose of this research was to evaluate a method of prompting parental disclosure of such problems and to determine the impact of parental disclosure on family physicians' identification of and intervention for childhood psychosocial problems. Participants were parents and physicians of 60 children between the ages of 3 and 10 years attending an ambulatory care clinic of a community-based, university-affiliated family medicine training program. Parents completed the Child Behavior Checklist and also indicated whether psychosocial problems were discussed or managed. Physicians completed a checklist about the psychosocial status of the child and potential interventions for identified problems. One half of the participating parents formed the experimental group and were also asked to note their concerns on a Psychosocial Checklist for Children and to discuss these concerns with their child's physician; the other half of parents received no such checklist and acted as the control group. All interactions between parents and physicians were videotaped. The data showed that the number of parental psychosocial disclosures, but not

the number of parents who disclosed them, was significantly higher for the experimental group. Physicians were three times as likely to identify a psychosocial problem and 10 times as likely to intervene when parents discussed psychosocial concerns."

Merrill JM, Laux L, Thornby JI. "Troublesome aspects of the patient-physician relationship: a study of human factors" *Southern Medical Journal* 80(10): 1211-1215, October 1987.

"We investigated three onerous aspects of the patient-physician relationship using contemporary psychosocial research methods. A "hassle index" identified three dimensions of vexation in practice: problems with running a practice, medical conditions of patients, and social characteristics of patients. In general, hassle was found to be dependent on the type of practice, but physicians were equally annoyed by unlikeable patients irrespective of their practice site. Diagnostic errors made by resident physicians from various clinics were more related to an unlikeable medical disorder than to differences in the clinics. To clarify doctors' negative feelings toward patients, a questionnaire measuring antipathy toward specific patient types was administered to physicians. Responses indicated that physicians' antipathy was unrelated to the doctors' ethical beliefs and their medicopolitical orientation. Personality variables indicative of "extremeness" of opinion about patients included high needs for dominance, low needs for nurturance and "intraception" (the ability to analyze the behavior and motives of others), and low self-esteem. Personality profiles of physicians least vexed by medical practice reflected less psychopathology—less self-derogation, less need for emotional support, and more extroversion. Medical College Aptitude Test scores revealed that high science scores were associated with extremeness of opinion, and low scores on general information were indicative of increased susceptibility to the daily irritations of medical practice."

Metz JR, Allen CM, Barr G, Shinefield H. "A pediatric screening examination for psychosocial problems" *Pediatrics* 58(4): 595-606, October 1976.

"In an effort to avert the cumulative effects of unresolved emotional problems on children's social and school adjustment, a psychosocial phase was added to a pediatric multiphasic examination. Based upon a cumulative stress concept, the screening procedures included child behavior and family stress questionnaires for parents, and abbreviated standard psychological tests for children, administered by specially trained aides. Computerized results were reported to the child's pediatrician. Follow-up by mental health counselors attached to the pediatric clinic was provided for patients identified as being at high risk of serious psychosocial problems. Evidence of validity of the screen, factors affecting the scores, and effectiveness of clinical follow-up of high-risk patients are discussed. Valid semicomputerized screening of school-age children for serious psychosocial problems can be carried out routinely and at relatively low cost by paraprofessional personnel in a pediatric setting. Impediments to effective use of the screening results on the part of both health care provider and patient are discussed."

Ong LM, de Haes JC, Hoos AM, Lammes FB. "Doctor-patient communication: a review of the literature" *Social Science and Medicine* 149(7): 903-918, April 1995.

"Communication can be seen as the main ingredient in medical care. In reviewing doctor-patient communication, the following topics are addressed: different purposes of medical communication; analysis of doctor-patient communication; specific communicative behaviors; the influence of communicative behaviors on patient outcomes; and concluding remarks. Three different purposes of communication are identified, namely: creating a good interpersonal relationship; exchanging information; and making treatment-related decisions. Communication during medical encounters can be analyzed by using different interaction analysis systems (IAS).

These systems differ with regard to their clinical relevance, observational strategy, reliability/validity and channels of communicative behavior. Several communicative behaviors that occur in consultations are discussed: instrumental (cure oriented) vs affective (care oriented) behavior, verbal vs non-verbal behavior, privacy behavior, high vs low controlling behavior, and medical vs everyday language vocabularies. Consequences of specific physician behaviors on certain patient outcomes, namely: satisfaction, compliance/adherence to treatment, recall and understanding of information, and health status/psychiatric morbidity are described. Finally, a framework relating background, process and outcome variables is presented."

Pantell RH, Stewart TJ, Dias JK, Wells P, Ross AW. "Physician communication with children and parents" *Pediatrics* 70(3): 396-402, September 1982.

"The purpose of this study was to document the content of medical interviews in routine pediatric visits and to identify demographic and situational characteristics that influenced the extent of communication between doctor and child. One hundred fifteen office visits to 49 physicians were videotaped and analyzed. Children studied were 4 to 14 years old with a mean age of 8.5 years. Verbal transactions were coded according to direction of communication, transaction type, and content category. Coder reliability for this system was 0.84. A considerable amount of the total communication, 45.5%, was between doctor and child. Doctors interacted differently with parents and children. More information about the current problem was obtained from children; physicians provided feedback primarily to parents. Parents received 4.4 times as much information as children about the nature and prognosis of a condition. The extent to which doctors talked to children in "substantive" areas was primarily associated with a child's age but was partly influenced by family size and family utilization. Race, socioeconomic status, type of problem, and previous encounter with the examining physician did not alter communication

patterns. Boys were given more information than girls. We suggest a theoretical framework for future investigation and teaching that identifies the child as an active participant in the medical process.”

Patterson JM. “Promoting resilience in families experiencing stress” *Pediatric Clinics of North America* 42(1): 47-63, February 1995.

“All families experience many different life events, strains, and hassles over their life spans. Stress emerges in the family when demands exceed capabilities. When this imbalance persists and becomes larger, children and other family members often show signs and symptoms of distress, including health-related problems. Pediatricians are increasingly called on to evaluate this situation and to be helpful to stressed families and their children. A family assessment model is presented to aid pediatricians in helping families to identify the sources and degree of stress they are experiencing, and even more importantly, to facilitate their ability to discover and use their own strengths and resources. The goal for the pediatrician is to promote balance and resilience in families, which, in turn, will contribute to better health and functioning in children.”

Sharp L, Pantell RH, Murphy LO, Lewis CC. “Psychosocial problems during child health supervision visits: eliciting, then what?” *Pediatrics* 89(4 Pt. 1): 619-623, April 1992.

“The purpose of this study was to determine the extent to which parents had opportunities to express psychosocial concerns and the nature of physicians’ responses to these concerns during health supervision visits. Analyzing videotapes of child health supervision visits by 34 children aged 5-12, the authors assessed (1) the nature of opportunities provided to express concerns, (2) categories of psychosocial problems expressed by parents and children, and (3) the nature of physicians’ responses. In 88% of the child health supervision visits, opportunities were created by the physician to discuss psychosocial concerns or were spontaneously raised by the parent or child. In half of the visits, parents or children expressed a total of 30

psychosocial concerns, such as conduct/behavior problems (47%), insecurity (13%), family, sibling, or social problems (13%), learning difficulties (10%), somatization (7%), and other (10%). Physicians’ responses to these psychosocial concerns were as follows: 17% ignored the concern; 43% asked further exploratory questions but provided no information, reassurance, or guidance; 3% reassured the parent; 27% responded with psychosocial information and/or action; 3% responded with medical information and/or action; and 7% responded with a combination of these latter two modes of actions.”

Stewart TJ, Pantell RH, Dias JK, Wells PA, Ross AW. “Children as patients: a communications process study in family practice” *Journal of Family Practice* 13(6): 827-835, November 1981.

“To determine how family physicians divide their attention between children and parents, 115 videotaped pediatric encounters of children (aged 4 to 14 years) and parents with family physicians in a family medicine center were analyzed. It was learned that physicians tended to involve children actively in the diagnostic stages of interviews but much less so in discussions of treating or dealing with their problems. Physicians did not alter this pattern as they advanced in training. Older children were more likely to receive direct communication from physicians in all phases of office encounters. Though the family physicians in this sample had more direct communication with children than reported in previous research, it is argued that greater involvement of children in all phases of pediatric visits is warranted.”

Street RL. “Communicative styles and adaptations in physician-parent consultations” *Social Science and Medicine* 34(10): 1155-1163, May 1992.

“This investigation compares the degree to which personal and interactive factors respectively account for variation in patterns of physician-parent communicative exchange. The analysis of audiorecordings of 115 pediatric consultations revealed several notable findings: (a) individual physicians differed in the degree to which each provided

information, issued directives, exhibited positive socioemotional behavior, and engaged in partnership-building, (b) parents who asked more questions and expressed more negative affect (eg, concerns, frustrations) received more information and directives from physicians, (c) parents who were more affectively expressive elicited a greater number of positive socioemotional comments from doctors, and (d) parents' question-asking and opinion-giving were related to the parents' level of education and the degree to which physicians' engaged in partnership-building."

Sunde ER, Mabe PA, Josephson A. "Difficult parents. From adversaries to partners" *Clinical Pediatrics* 32(4): 213-219, April 1993.

"The pediatrician's job becomes frustrating when it is necessary to deal with difficult parents. Some physicians may not have the training or inclination to engage such parents in a therapeutic partnership. This paper discusses tools available to physicians which will help them develop an effective partnership that includes uncovering the hidden meaning behind a child's illness; understanding the reciprocal nature of partnerships; and the importance of determining each party's goals, roles, and expectations. Negotiating these steps enables physicians to develop a productive relationship with difficult parents of sick children. This strategy can facilitate the child's medical care and improve the parents' and physician's satisfaction with the services rendered. This paper also discusses steps to take when these attempts are not sufficient to handle the situation."

Tellerman K, Medio F. "Pediatrician's opinions of mothers" *Pediatrics* 81(2): 186-189, February 1988.

"The purpose of this study was to determine factors that influence pediatricians' opinions of mothers. The degree to which mother-physician interactions, mother-child interactions, and maternal demographic variables influence pediatricians' opinions of mothers was assessed with a 54-item

questionnaire. A majority of the 230 pediatricians who responded reported that their opinions were 'greatly' positively influenced by mothers who communicate clearly (60%), understand recommendations (56%), follow recommendations (68%), and keep appointments (58%). In comparison, significantly fewer pediatricians' opinions were 'greatly' influenced by mothers who are friendly to them (38%) or who like them (34%). Pediatricians were also 'greatly' influenced by mothers who seem safety conscious (67%), use car restraints (57%), and keep immunizations updated (61%). Female pediatricians, in contrast to men, were significantly more influenced by mothers who 'respond to their crying infants' and who 'try to calm an anxious child.'"

Triggs EG, Perrin EC. "Listening carefully. Improving communication about behavior and development. Recognizing parental concerns." *Clinical Pediatrics* 28(4): 185-192, April 1989.

"A simple checklist was developed for completion by parents prior to their regular meetings with their pediatricians for health supervision. Its efficacy in improving communication between pediatricians and parents about behavioral and developmental concerns was evaluated. Without the checklist, 30% of parents' concerns were discussed. More items overall, and more items that were concerns of the parent, were discussed with the use of the checklist than without it. An intermediate but statistically significant effect was observed even when the pediatrician did not see the completed checklist; this effect was increased when he did (53% of concerns discussed). There were marked differences among pediatricians in the number of concerns that were discussed both with and without use of the checklist. Items regarding patterns of family life and child care, death or illness, siblings, and other stresses of modern families were frequently indicated as concerns on the checklist but were less frequently discussed. The data demonstrate the effectiveness of a simple and efficient method to improve communication about

children's behavior and development between their parents and their pediatricians."

White J, Levinson W, Roter D. "Oh, by the way..." The closing moments of the medical visit" *Journal of General Internal Medicine* 9(1): 24-28, January 1994.

"The purpose of this research was to define and describe the communication between physicians and patients in the closing phase of the medical visit, and to identify types of communication throughout the visit that are associated with the introduction of a new problem during the closing moments of the visit or with longer closures. Using audiotaped office visits, the authors found that physicians initiated the closing in 86% of the visits. The physicians clarified the plan of care in 75% of the visits and asked whether the patients had more questions in 25% of the cases. The patients introduced new problems not previously discussed in 21% of the closures. New problems in closure were associated with less information exchanged previously by physicians and patients about therapy, fewer orientation statements by physicians, and higher patient affect scores. Long closures (>2 minutes) correlated with physicians' asking open-ended questions, laughing, showing responsiveness to patients, being self-disclosing, and engaging in psychosocial discussion with patients."

Williamson P, Beitman BD, Katon W. "Beliefs that foster physician avoidance of psychosocial aspects of health care" *Journal of Family Practice* 13(7): 999-1003, July 1981.

"Although training in family medicine emphasizes a biopsychosocial approach to patients, many residents experience difficulties in carrying out the appropriate psychosocial part of their diagnosis and treatment. There are a set of core tacit beliefs which inhibit physicians from thinking psychosocially about their patients. These beliefs appear to be rigidly held but not

examined or challenged. This paper presents the major of these beliefs and for each a more realistic therapeutic reply. They are grouped into three categories: (1) beliefs concerning physician's role (eg, 'I must rule out organic disease; only then can I focus on psychosocial problems'), (2) beliefs concerning what the patient supposedly wants or does not want (eg, 'My patients want me to rule out organic problems'), and (3) physicians' fears about approaching patients as people (eg, 'If the patient has the same problem I do, how can I help if I have not helped myself'). By making overt these tacit assumptions, this paper attempts to highlight core barriers to the implementation of biopsychosocial care, increase understanding of effective alternatives, and challenge physicians to examine their hidden beliefs about patient care and their approach to patients."

Wissow LS, Roter DL, Wilson ME. "Pediatrician interview style and mothers' disclosure of psychosocial issues" *Pediatrics* 93(2): 289-295, February 1994.

"Primary care pediatricians play an important role in the detection, diagnosis, treatment, and referral of children with mental health problems. Some parents, however, are reluctant to discuss behavioral and emotional symptoms with their child's pediatrician. Studies of patient-physician communication suggest that specific aspects of pediatrician interview style (asking questions about psychosocial issues, making supportive statements, and listening attentively) increase disclosure of sensitive information. The authors hypothesized that disclosures of parent and child psychosocial problems would be more likely to occur during visits when pediatricians used these techniques. Study results found that the use of psychosocially oriented interviewing techniques was associated with a greater likelihood of disclosure for all four of the topic areas studied. Odds ratios for disclosure, adjusted for parental concerns and child age, ranged from 1.09 to 1.22 depending on the interview technique and outcome involved. Positive associations were observed both for topics raised primarily in response to pediatrician questions

(family and parent problems) and for topics raised primarily by mothers (behavior and punishment).”

Worchel FF, Prevatt BC, Miner J, Allen M, Wagner L, Nation P. “Pediatrician’s communication style: relationship to parent’s perceptions and behaviors” *Journal of Pediatric Psychology* 20(5): 633-644, October 1995.

“Investigated physician-parent communication styles and the effects of concordance between parent’s desired communication styles and the communication style exhibited by physicians. Subjects were 107 parents of children scheduled for an appointment with a pediatrician at a general medical clinic. Parents and physicians completed rating forms indicating the degree to which parents desired each of four communication styles (information giving, interpersonal sensitivity, partnership, and directing one’s own treatment). Parents and physicians also rated the degree to which they believed the physician exhibited each of these four styles. Follow-up interviews with parents assessed the level of satisfaction with the visit, perception that parent’s concerns had been addressed, and subsequent telephone calls to the physician. Results indicated that physicians underestimated the degree of interaction desired by the parents. Parent desires for particular communication styles were not predicted by characteristics of the parents. Interaction variables predicted parent perceptions and subsequent need for contact with the physician.”

**RESOURCES FOR PATIENTS
AND THEIR FAMILIES**

Suggested Readings for Patients

Parental Addiction

children

Black, Claudia. *My Dad Loves Me, My Dad has a Disease*. Denver, CO: MAC Publishing, 1997.

Carrick, Carol. *Banana Beer*. Morton Grove, IL: Albert Whitman & Company, 1995.

Heegaard, Marge. *When a Family is in Trouble*. Minneapolis, MN: Woodland Press, 1993.

Langsen, Richard C. *When Someone in the Family Drinks Too Much*. New York, NY: Dial/Penguin Books, 1996.

Shles, Larry. *Scooter's Tale of Terror: A Fable of Addiction and Hope*. Carson, CA: Jalmar Press, 1993.

adolescents

Balcerzak, Ann. *Hope for Young People with Alcoholic Parents*. Center City, MN: Hazelden Educational Materials, 1981.

Berger, Gilda. *Alcoholism and the Family*. New York, NY: Franklin Watts, 1993.

Leite, Evelyn and Pamela Espeland. *Different Like Me*. Minneapolis, MN: Johnson Institute, 1987.

Center for Substance Abuse Prevention. *If Someone Close Has a Problem with Alcohol or Other Drugs*. Rockville, MD: Center for Substance Abuse Prevention, 1997.

Child Abuse and Neglect

children

Aust, Patricia. *Benni and Victoria: Friends Through Time*. Washington, DC: Child Welfare League of America, 1996.

Evans, Grace and Doris Sanford. *I Can't Talk About It: A Child's Book About Sexual Abuse*. Portland, OR: Multnomah Press, 1988.

Sanders, Pete and Steve Myers. *Child Abuse: What Do You Know About It?* Brookfield, CT: Copper Beech Books, 1996.

Stanek, Muriel. *Don't Hurt Me, Mama*. Morton Grove, IL: Albert Whitman & Co., 1987.

adolescents

Coman, Carolyn. *What Jamie Saw*. New York, NY: Puffin Books, 1997.

Howe, James. *The Watcher*. New York, NY: Atheneum Books for Young Readers/Simon and Schuster, 1997.

Hunt, Irene. *Lottery Rose*. Madison, WI: Demco Media, 1992.

Mazer, Norma Fox. *Silver*. New York, NY: William Morrow and Company, 1988.

Child-Witnessed Domestic Violence

children

Bernstein, Sharon Chesler. *A Family That Fights*. Morton Grove, IL: Albert Whitman & Co., 1991.

Greenberg, Keith. *Family Abuse: Why Do People Hurt Each Other?* New York, NY: Henry Holt & Co., 1995.

Rench, Janice. *Family Violence: How to Recognize and Survive It*. New York, NY: Lerner Publications, 1992.

Trottier, Maxine. *A Safe Place*. Morton Grove, IL: Albert Whitman & Co., 1997.

adolescents

Byars, Betsy. *Cracker Jackson*. New York, NY: Viking Press, 1996.

Child and Adolescent Substance Abuse

children

Fettig, Art. *The Three Robots Learn About Drugs*. Battle Creek, MI: Growth Unlimited, Inc., 1987.

Vigna, Judith. *My Big Sister Takes Drugs*. Morton Grove, IL: Albert Whitman & Co., 1990.

adolescents

Center on Substance Abuse Prevention. *Tips for Teens (Alcohol, Hallucinogens, Marijuana, Smoking, Steroids, AIDS)*. Rockville, MD: CSAP, 1996.

Harvard School of Public Health. *A Guide for Teens: Does Your Friend Have an Alcohol or Other Drug Problem?* Cambridge, MA: Harvard School of Public Health, 1994.

National Institute on Drug Abuse. *Crack Cocaine: The Big Lie*. Bethesda, MD: NIDA, 1991.

National Institute on Drug Abuse. *How Not to Get High, Get Stupid, Get AIDS: A Guide to Partying*. Bethesda, MD: NIDA, 1993.

Resources for Patient Education Materials

Al-Anon Family Group Headquarters, Inc.
1600 Corporate Landing Parkway
Virginia Beach, VA 23454-5617
(757) 563-1600
www.al-anon.alateen.org

Alcoholics Anonymous
PO Box 459, Grand Central Station
New York, NY 10163
(212) 870-3400
www.aa.org

American Council for Drug Education
164 W. 74th Street
New York, NY 10023
(800) DRUG-HELP
www.acde.org

Child Welfare League of America
440 First Street, NW, Third Floor
Washington, DC 20001-2085
(202) 638-2952
www.cwla.org

Children of Alcoholics Foundation
164 W. 74th Street
New York, NY 10023
(212) 595-5810 x7760
www.coaf.org

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100
www.modime.org

National Clearinghouse for Alcohol and Drug Information (NCADI)
PO Box 2345
Rockville, MD 20847-2345
(800) 729-6686
www.health.org

National Clearinghouse on Child Abuse and Neglect Information
330 C Street, SW
Washington, DC 20447
(800) 394-3366
www.calib.com/nccanch

National Committee to Prevent Child Abuse
332 S. Michigan Avenue, Suite 1600
Chicago, IL 60604
(312) 663-3520
www.childabuse.org

National Council on Alcoholism and Drug Dependence
12 W. 21st Street
New York, NY 10010
(212) 206-6770
www.ncadd.org

National Institute on Alcohol Abuse and Alcoholism
Suite 409
6000 Executive Boulevard- Willco Building
Bethesda, MD 20892-7003
www.niaaa.nih.gov

National Institute on Drug Abuse
6001 Executive Boulevard
Bethesda, MD 20892-9561
(301) 443-1124
www.nida.nih.gov

National Organization for Victim Assistance
1757 Park Road, NW
Washington, DC 20010
(202) 232-6682
www.try-nova.org

**National Organization on
Fetal Alcohol Syndrome
418 C Street NE
Washington, DC 20002
(202) 785-4585
www.nofas.org**

**Parents Anonymous
675 W. Foothill Boulevard., Suite 220
Claremont, CA 91711
(909) 621-6184
www.parentsanonymous-natl.org**

**Resource Center on Domestic Violence, Child
Protection, and Custody
National Council of Juvenile and Family
Court Judges
PO Box 8970
Reno, NV 89507
(775) 784-6012
www.ncjfcj.unr.edu**