Preface

The Origins and Purpose of This Book

I began my fellowship in 1966 as a 31-year-old board-certified pediatrician eager to learn the subspecialty of pediatric gastroenterology. The model of clinical practice that I knew was the standard biomedical model, whose clear-cut goals were the diagnosis and cure of organic diseases. I was unaware of any other model and believed that psychological or social problems were separable parts of illnesses that could and should be handled only by mental health professionals. My job was to cure diseases.

I shall never forget an early experience I had during ward rounds with Dr. Giulio Barbero, my mentor at Children's Hospital of Philadelphia. A 9-year-old patient with complaints of abdominal pain that prevented his going to school had been referred to Dr. Barbero after failure of many diagnostic evaluations and therapeutic trials. I remember my alarm when I asked Dr. Barbero what we would do if we, too, could not find a disease or cure for the child's pain. How could we honestly offer to help him? I was afraid that my mentor was trying to teach me how to be a charlatan and that he falsely implied to the parents that, if they allowed him to hospitalize their child, some good could come of it. How could any good come of it? The parents staunchly believed that their child was afflicted with an organic disease that no previous physician was smart enough to diagnose. I feared we could do no better.

Much good resulted from this hospitalization, although I could not grasp it at first. Dr. Barbero used the biopsychosocial model of clinical practice, years before the term was coined [1], which included individual diagnostic interviews with each parent and measures aimed at bringing to light and limiting secondary gain. Very dramatic healing took place. Not only was the iatrogenic anxiety caused by previous "wantonness of inquiry" [2] relieved, but also the connection between the mother's emotional difficulties and what was driving the child's dramatic complaints, namely, the child's unrecognized anxiety, was brought to light. And it was accomplished in a way that strengthened rather than weakened our rapport and enabled them bring an end to their child's abnormal illness behavior.

It took me about 6 months to be fully won over and become an advocate of the bio psychosocial model—a difficult adjustment for me. I had not felt comfortable delving into patients' intimate experiences and feelings. Taking a conventional history had been what I was used to; it was less open-ended, more focused on finding a disease, and less time-consuming. History taking in the biopsychosocial mode turned out to resemble what another pioneer in biopsychosocial pediatrics, Dr. Morris Green, called "the diagnostic interview" [3]. Some time passed before I allowed myself to drift into existential reality and to have feelings for patients beyond "professional detachment" and "scientific objectivity" [4]. The biopsychosocial model fostered *engagement*, the antithesis of *abstraction*, which, in the words of Edmund Murphy, "may be too easily used as an evasion of commitment and responsibility" [5]. And it opened vistas for learning that enhanced my understanding of illness. My willingness to adopt this model of practice was inspired by Dr. Barbero's teaching-by-example and sustained by an interest in, and aptitude for, the psychological aspects of patients and their illnesses acquired during a formal psychoanalysis that I underwent as a young adult.

A large body of literature exists on functional GI disorders in children [6, 7]. Functional syndromes have been well described insofar as their symptoms, epidemiology, and, in some cases, their physiology. Although these disorders are common and cause distress in families, management techniques have generally not been the major focus of investigation. This neglect may be attributed in part to the relative paucity of symptom-ameliorating medications that "fix" such problems. Of greater moment is the dominant biomedical model of practice that is best suited to address "real" organic diseases and does not foster enthusiasm for functional disorders. However, a satisfactory clinical outcome often depends on the clinician's ability to discern not only the biological factors in illness but also the unique cognitive and emotional needs that patients bring to the task of healing.

A colleague once asked me whether I considered myself a clinical investigator. I said no, I didn't do drug trials or statistical surveys of cohorts of patients I did not personally know. Rather, I aspired to be a "clinical naturalist," guided by (what one parent called) an attitude of "concerned inquisitiveness," combining sincere caring for patients with naturalistic observation and collection of data that, in time, might yield relatively new and useful information. There were two practical elements to this process: "the workbook" and "the card file."

The workbook: During my fellowship, Dr. Barbero required his fellows to take histories using a workbook of a dozen or more pages. The first two pages were blank for the writing of the Chief Complaint and the History of the Present Illness. The remaining pages contained questions regarding the past and family histories as well as developmental aspects of the patient, the parents, their life experiences, and current concerns.

I dispensed with the workbook as soon as I finished training because, in everyday practice, its many seemingly unimportant questions took up so much time. I quickly discovered that not asking the "unimportant questions" resulted in a shorter encounter, but one that left me without really having a grasp of what was actually bothering the patient and, therefore, not having anything to offer much beyond what the referring doctor had told them. So, I reconstructed a workbook and decided to take

the time to ask the "unimportant," open-ended questions and listen to where patients' answers led. More often than not, clues that emerged during this somewhat time-consuming process were well worth the time spent.

The card file: As a child, I had the benefit of a mother who was not only loving but also had a reverence for Nature. Whether it was in the bedtime stories she read to us or the interest she showed during walks in the park, she made descriptive observations and their correlative meanings important to us.

When I entered practice in 1970, I was inclined to look upon the clinical realities I encountered as phenomena of Nature—encounters that could be learned from, provided I made the effort to record and collect them as data. Therefore, I developed a card file (computers were not affordable back then). Each time I dictated a report on a new patient, I asked my secretary to put a punch card into one or more of its 50 or 60 diagnostic slots. In time, the card file enabled me to retrieve and analyze whole categories of patients' charts. That process of collection and analysis was the basis for, e.g., the publication in 1993 of a review of 71 children with Cyclic Vomiting Syndrome [8], and for the previously unpublished data cited in the chapters of this book.

The chapters that follow are drawn from my personal experience as a hands-on, full-time clinical practitioner of pediatric gastroenterology for over 44 years. They describe, in an admittedly idiosyncratic way, the details of my practice using the biopsychosocial paradigm, including naturalistic descriptions of functional gastrointestinal disorders, clinical goals, and the theoretical bases for management techniques. They are an attempt to share what I've learned with colleagues who work with children and families.

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