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Interdisciplinary Teamwork and Systemic Care in Pediatric Psychology: Focus on Early Childhood

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1. Introduction

Several *chronic childhood illnesses* become evident at birth or during the first months of life, so parents have to cope not only with the natural crisis of parenthood (see Danis, 2020 for more details) during early childhood, but also with the daily tasks related to the sick child, medical interventions, hospital stays, or separation, etc.

The early childhood period can also present a range of difficulties in *the regulation of states, emotions and behaviors* (e.g. *excessive crying*: Long, 2004; St. James-Roberts, 2012; *problems falling asleep and staying asleep*: Bower & Ray, 2006; Mindell et al., 2010; *eating disorders:* Chatoor, 2009) that can be associated with physical symptoms, which drive parents to health care. These symptoms are remarkably common, affecting 5-15% of the infant and young child population (Hédervári-Heller, 2008/2020; ZERO TO THREE, 2016/2019), and may involve interactions of organic and psychosocial, relational influences in both etiology and observed symptom functioning.

The diagnostics and treatment of eating disorders (which is the main topic of our case study) is of great interest in international practice and now in Hungary too. Since the etiology of eating disorders is complex and different types of eating problems can be identified (e.g. Chatoor, 2009), this differential diagnostic process also determines how an effective treatment plan is set up, which in most severe cases can only be achieved through *interdisciplinary teamwork.* The timing and targeting of interventions is key: the most effective methods are complex, systemic, family-centered care that must be provided as early as possible and can be delivered in both primary and specialist care.

Today, interdisciplinary teams are working effectively in many areas of pediatrics (e.g. eating disorders, chronic pain, diabetes management, physical rehabilitation). Multi-, inter- or trans-disciplinary teams (Choi & Pak, 2006) involve several health specialists (pediatricians, psychologists, nurses, clinical social workers, dieticians, developmental therapists, etc.) working together. Usually, during the diagnostic process, each specialist assesses the child and his/her family and then they jointly develop a treatment plan. Each professional offers the services that they are qualified to provide to the family. Ideally, this is integrated into a comprehensive treatment plan. Inter-

disciplinarity therefore no longer just means that, in a good case, a number of professionals are working "under the same roof" towards the same goals, but also that these goals are shared and there is intensive collaboration for the benefit of patients. There can also be some crossing of professional boundaries, and in *transdisciplinary work* there can be a high degree of shared competences, and tasks can be delegated, and information can be represented and passed on to the family in a uniform way by different professionals.

In *family-centered care (FCC;* for more on the concept, see Mikkelsen & Frederiksen, 2011), care is organized around the whole family. FCC is, to the best of our knowledge today, the most effective way to care for sick children. In the *family-centered therapeutic triad*, the child, his/her family, and the care team work together, and this system is integrated into the wider social environment (Kazak et al., 2002).

From the beginning, pediatric psychology has used *family-focused interventions*. General systems theory inspires the use of the theoretical frameworks of transactional theory and social ecological models, and the use of a variety of systemic and family therapeutic approaches (Mullins et al., 2014). During infancy and early childhood, *parent-infant consultation and therapy* (see for more details Hámori, 2020; Hédervári-Heller, 2008/2020; Hédervári-Heller, 2020; Németh & Hédervári-Heller, 2020) can also provide a systemic and attachment-based form of care that can effectively address most early childhood interaction problems with physical and behavioral symptoms.

2. Outpatient Hospital Management of Feeding and Growth Disorder Through Family/Parent-infant Consultations and Interdisciplinary Teamwork

The following is a fictitious case used to illustrate the possibilities discussed in the theoretical introduction through the work of a clinical health psychologist with families of infants and young children attending pediatric wards. In the case study, the general characteristics of several cases, possible forms of support, and the dilemmas and obstacles encountered in working with families, as well as possible solutions will be presented focusing on the role of the psychologist. A description of the general activities of the psychologist before presenting the case helps to put the care provided into context. In this fictional case study, we aim to present outpatient, interdisciplinary treatment options for a type of early eating disorder.

2.1. Pediatric Psychologist in a Hungarian Hospital

In the second half of the 2010s, the Department of Internal Medicine and the Department of Gastroenterology of a Budapest children's hospital collaborated providing interdisciplinary care for, among others, early childhood feeding disorders. The team

consists of pediatricians (internists and gastroenterologist specialists and practitioners), a dietician, a psychologist, a parent-infant/young child consultant, nurses and a physiotherapist. The practicing health psychologist with a background in developmental psychology, couple and family therapy, and parent-infant consultation volunteers to carry out duties in the department, which usually include:

- *Management of emotional and behavioral difficulties caused by acute illnesses during hospital stay (parent, child, and parent-child consultations at the bedside; parent-physician-psychologist team collaboration).* As part of the daily operations, the psychologist consults several times at the bedside with parents, families, or even with children separately after permission by the parents, (e.g. in times of forced separation, regular age-appropriate "visits" are a particularly important form of support for children: talking, playing, drawing together, etc.). At the morning staff meeting, the medical team indicates which inpatient children and their families should be visited. Sometimes the parents indicate that they would like to talk to the psychologist, sometimes the doctors and nurses request that the psychologist visit a child and his/her parents. The psychologist is always introduced to the parent by the doctor who then explains his or her point of view on why he or she feels a brief consultation is appropriate. If the parent agrees, the psychologist will talk to the family at the patient's bedside or, where appropriate, with parental permission, a brief consultation with older children and adolescents. In the case of young children, the parent is present in every case, except if they are forced to separate due to their living conditions. Methodologically, these short 15–25-minute sessions consist of short supportive talks, emotional support, information transfer, psychoeducation, games, drawing, etc. The topics are mostly related to the child's development, behavior, care or the parent's emotional states and concerns. The consultation focuses primarily on the illness and its treatment, but general developmental and family functioning issues may also be raised. In case a piece of information emerges in the discussion that the psychologist thinks it needs to be shared with the doctors or nurses involved, he or she will ask for permission to share this information and, if possible, encourage this in a parent-child-physician-psychologist team, acting as a mediator. If, together with the doctor, they consider that more than one consultation after hospitalization is warranted, he or she will offer parents outpatient appointments or encourage them to seek out another professional or institute.
- *Periodic management of chronic illnesses in the ward (parent, child, and parent-child consultations at the bedside; parent-physician-psychologist team collaboration).* Sometimes young children with chronic illnesses (e.g. young children with cystic fibrosis awaiting lung transplantation or children with chronic digestive or respiratory problems) and their parents return to the ward and are met by the psychologist on several occasions. In these cases, he or she provides emotional support and talks to parents and relatives about issues of development and the home management of the disease,

and also interacts with the children in a playful way. In cases of increased parental or family psychological difficulties, he or she offers outpatient and other psychological support.

- *For infant and toddler regulatory problems (e.g. feeding disorders, sleep disorders, chronic crying, restlessness), weekly outpatient parent-infant/young child consultations or family therapy as part of the work of the team.* Care for young children and their families is provided by doctors, dieticians, physiotherapists, and nurses who work in a team. The psychologist, following a medical examination, mostly provides parent-infant/young child consultation or family therapy for various (e.g. infantile anorexia, sensory food aversion and illness-related or post-traumatic food refusal) eating and growth disorders (e.g. Chatoor, 2009; Scheuring et al., 2016). A fictional case illustration of this work is presented below.
- *Conducting intervisional case discussions in a doctor-psychologist team.* Case discussions on dilemmas, questions and concrete actions to be taken regarding the etiology and treatment of different early childhood psychosomatic disorders are held between the psychologist and the doctors interested in psychosomatic disorders.
- *Psychological support for the professionals providing care.* In some traumatic cases or in cases of severe psychological exhaustion, the psychologist is also consulted by the professionals working in the department. Short support sessions are then held, either individually or in groups. If there is a risk of burnout or suspected post-traumatic stress, external specialist help is recommended.

3. Fictitious Case of a Hospital Outpatient

Twenty-two-month-old Zalán and his parents (Zsuzsa, 32, nursery teacher, Bálint, 34, carpenter) live in a small village in Nógrád county in modest circumstances. Zalán is visiting a dermatologist at the hospital because of a prolonged skin infection that is difficult to cure. During the routine physical examination, the dermatologist notices Zalán's thinness and advises the parents to consult the interdisciplinary team of the department of internal medicine, who investigate and treat feeding problems in both in- and outpatient setting.

At the first consultation, the family will meet the pediatric internist and the health psychologist working in the department. The meeting takes place in an outpatient room furnished with a play mat, toys, and comfortable chairs. The pediatrician in charge of the team indicates that the experience of the first consultation will be the basis to determine exactly what examinations to expect and which specialists will deal with the symptoms by the team. To this end, in addition to a routine physical examination, the team will first ask medical questions about Zalán's current and past development, health, feeding history, and then ask the psychologist to take a more extensive

anamnesis to clarify symptoms, parental attitudes and behavior, and the relationships in the family.

Given the rapid movements, highly active temperament and lean physique of the young child, and the history of feeding, infantile anorexia syndrome (see box), a kind of feeding disorder, is deemed highly probable. It is based on a diagnostic system that has been used abroad for decades but is less well known and hardly used in Hungary (Chatoor, 2009; DC:0-3R: ZERO TO THREE, 2005).

Infantile anorexia

Infantile anorexia syndrome usually appears in infancy and early childhood (typically between 6-36 months of age). The infant/young child regularly refuses food and shows no interest or curiosity in eating and food. He/she may run away from feeding situations or it may be impossible to bring him/her into a feeding situation (runs, does not sit down at the table). Parents often seek help only in case of a growth disorder. Symptoms often include increased alertness and curiosity, general restlessness, hyperactivity, and sleep disturbance. In the development of feeding, the transition to independent, patient spoon- or pinch-feeding is one of the most typical times of onset. Dietetic studies most often show that the intake of food is not age-appropriate in terms of quantity and quality, and physical and laboratory tests often reveal deficiencies. In accordance with the diagnostic criteria, stagnation of weight gain followed by a fall of two major percentiles over a period of 2-6 months is typical. Children are smaller, more fragile and thinner than average, while their head circumference is appropriate for their age. Feeding difficulties are not usually due to organic disease and are not related to a traumatic experience involving the oropharyngeal or gastrointestinal system. Children are active, curious, and very sensitive to external environmental stimuli (sights, sounds, etc.), which can distract them from eating. They typically do not notice and thus do not signal that they are hungry. It seems from their parents' accounts that 'everything else is more important to them than eating'. Because of regular food refusals, parents usually use a variety of distraction strategies and sometimes force-feeding to make up for the amount of food they clearly lack. Most of the time we also see family dynamic consequences: not only the child and parents, but the whole family is affected by the “fights” and frustrations around meals.

It is assumed that feeding disorders are clearly caused by temperamental characteristics (overactivity, irritability, difficulty in calming down), immaturity and sensitivity of the nervous system, and problems with the regulation of internal body sensations (e.g. hunger, satiety). The infant/young child is more interested in and attentive to external circumstances and environmental stimuli than to internal bodily “messages”. The key to solving this problem, in addition to medical and dietary considerations, is to promote parent-child interactions linked to daily interactions (care situations, play) and specifically to eating. Psychological consultation focuses on reducing anxiety in both the child and the parents, child resistance and parental coercion or abandonment due to inertia, frustration-induced scenarios and fights about eating, in addition to creating predictability in the daily schedule and meals, recognizing the power of shared meals, and setting behavioral limits and frameworks (sensitive discipline). (Chatoor, 2009; ZERO TO THREE, 2005; also Scheuring et al., 2016)

After an educational summary of the symptoms, parents anxiously recall how they have always felt “something was wrong”, how Zalán has always eaten too little and was “tiny”. He was always on the move from the time he started walking, he was running,

messing around, asking questions, “always misbehaving” and it has hardly been possible to make him eat. This behavior and the low intake of food were reported to the pediatrician and the nurse, who advised them to be patient, as the child was showing age-appropriate behavior in terms of vitality and psychomotor development. Zalán accepts food at the nursery (which he has been attending since he became 16 months old), but there, pureed food is common, and he does not eat independently yet. At home, he sometimes accepts solid food, but always eats very little. He just runs around all the time, he is busy playing. He may refuse food all day or only take a bite at a time. It has become the habit of his parents to put snacks (small biscuits, puffs, millet balls, crackers) on the table and Zalán takes them whenever he feels like it. “So at least he eats something,” says the mother sadly. They rarely sit down together at the table. On these occasions, Zalán starts to eat, but if anything disturbs him (whether it is the dog barking or the siren of an ambulance outside), he stops eating immediately and runs to look out the window.

At 22 months Zalán weighed 10 kg. He was born at 38 weeks as a healthy newborn, weighing 3390 g. His mother had a difficult start with milk, and for the first few days she supplemented his breast milk with formula, until her milk completely ran out at 5 weeks. From then on, they switched completely to formula, which Zalán always ate a lot of as a baby and still eats in the morning and evening.

At six months, he started to eat mashed food and his parents said he was eating well (he would sometimes even accept large bottles). At 12 months, he weighed 8 kg. Figure 1 below shows that Zalán's weight decreased steadily during the first year of life and by the age of one, he was only in the 10th percentile. Shortly afterwards (at 16 months) he went to nursery, and since then, he has not really accepted food at home, and his weight has continued to fall below the expected weight: he is now well below the 3rd percentile curve (Figure 2), so there is a clear problem of weight gain. He appears to be active and vital, with no physical problems apart from being thin. However, it turns out that he never has solid stools. Zalán is very “active and strong-willed” according to his parents, and he is constantly demanding to be with his parents from infancy and is fiercely resisting anything that is not done the way he wants it to be done.

Parents seem motivated and engaged from the very first moment. The father says he was a similar child: “a spoonful of soup, a run around the house, that was the custom in the village”, as his relatives used to say. They used to live far away, in Baranya county, where they both come from, but five years ago, at the beginning of their relationship, due to the father's job (at a large carpentry workshop), they moved to Nógrád County. They have no help around here, but they visit their parents whenever they can, because they all like to be with them.

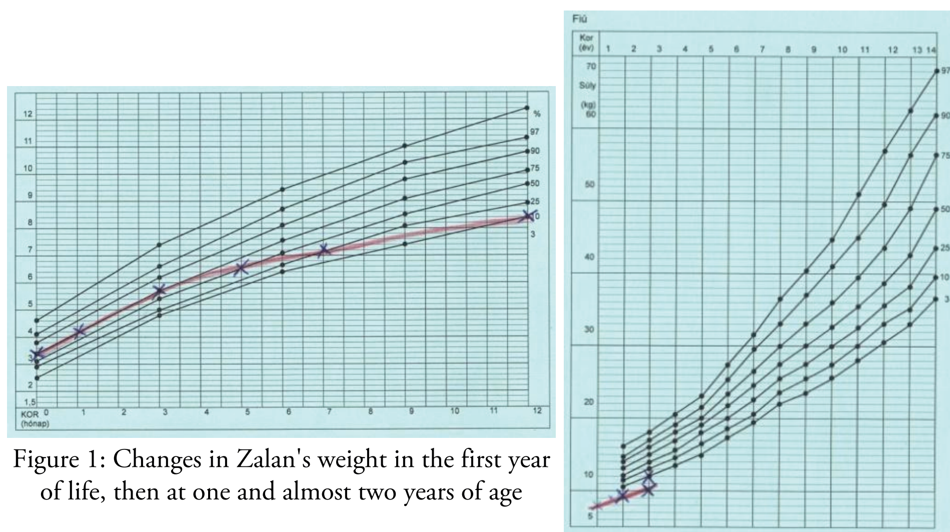

Figure 1: Changes in Zalan's weight in the first year of life, then at one and almost two years of age

After the first appointment, the doctor informs the parents about the medical examinations that will be carried out in the next two weeks. There is no need for inpatient care; the child will continue to receive care on an outpatient basis. The psychologist asks the parents to keep a detailed four-day food diary (two days at nursery, two days at home), recording the time, duration, type, and quantity of each meal and asks for the cooperation of the nursery teacher in writing to do the same. It is agreed that the parents will send the diary by email, which will be analyzed not only by the psychologist and the doctors but also by the dietician colleague, who is expected to be involved in one of the consultations. The parents are hopeful that Zalán's feeding and growth will soon improve.

At the first meeting, the relationship between the mother and the father seems to be harmonious, supportive and a source of strength for each other in their daily lives. Their relationship and their caring attitude and concern for Zalán are an important background for successful work. They are worried and uncertain about how to reverse the process, and openly rely on the help of doctors and psychologists. Their problem-solving skills, mobilizable peer support and positive outlook bode well for their prognosis, even though according to literature, creating a lasting solution to similar feeding problems is a long process.

To the second session, the psychologist will invite another resident pediatric colleague who is part of the team, who has already consulted the dietitian colleague before the meeting and who will represent his/her views (see transdisciplinary teamwork). Since the medical tests ordered previously (physical examination, detailed laboratory tests, stool analysis, ultrasound) do not indicate an organic background (lesion, malabsorption, milk allergy, coeliac condition, etc.), the doctor focuses on the feeding-

eating issue. Based on the food diary he or she will ask about all the meals of a typical day. The preliminary consultation with the dietician concluded that Zalán is not getting enough of all the nutrients. Most of the accepted foods are protein (formula), but many nutrients and vitamins are missing from the natural diet. Following a preliminary team meeting (with the team leader, the resident colleague, the dietician, and the psychologist), the resident doctor offers a calorie-rich, high-energy drink enriched with vitamins and trace elements, which she suggests the child drink in the evening, as this will help to make the nights more restful, while Zalán may still be hungry in the morning, which is important for teaching him effective eating behavior. He/she also recommends some syrups and drops to stimulate appetite. The team calls the parents' attention to the fact that the main goal is to establish a predictable daily eating rhythm and to help Zalán learn to recognize and satisfy hunger and fullness. Parents are reassured that the complementary foods offered and the vitamin supplements already taken are very important, so Zalán can slowly stop taking them parallel with the establishment of eating habits (the process corresponds to international guidelines, e.g. Chatoor, 2009). The doctor and the psychologist present the treatment plan together, also taking into account the parents' views. Behavioral support for eating will be provided by the psychologist, but the family will also meet with the doctors and the dietician from time to time during consultations. As the family lives far from Budapest, bi-weekly meetings are arranged in the mornings so that the father can still go to work afterwards.

During the rest of the consultation, the psychologist continues to lead the discussion while the resident colleague leaves and says goodbye to the family. In the parents' report, all three major symptom clusters of "infantile anorexia" are present as defined by the American diagnostic guidelines (Chatoor, 2009; DC:0-3R: ZERO TO THREE, 2005):

1) Zalán is an active, "constantly moving" child with a high level of nervous excitement;
2) There is a generational repetition: the father was a similar toddler, also living with eating difficulties; and even now, he follows a similar eating pattern (works all day in the carpentry workshop, often forgets to eat and drink, has a thin, lean build, and, he often eats properly only in the evening),
3) The generally observed autonomy-boundary-control problems also appear in the parent-child relationship, in discipline, in care situations and around mealtimes.

Education about important information is provided, and the psychologist, together with the parents, identifies that Zalán's story "fits" all aspects of this syndrome. This has a biological and a behavioral background, which is discussed in detail. Parents are given information that, in addition to medical monitoring, a behavioral intervention program can be effective, based on international experience (Chatoor, 2009). Parents remain motivated. It is agreed that consultations will take place in family sessions

where the young boy and both parents will be present. They attend 8 sessions every two weeks, 90 minutes each time. At the last session, mutual feedback is given, and a decision is made as a team on how to proceed with the consultation and the frequency of the meetings. The goal agreed with the parents in the team is to improve feeding-eating behavior, so that the child starts gaining weight. To this end, as described above, before/alongside the start of behavioral and attachment-theory-based intervention, Zalán will be given complementary formula, the amount of which will be reduced in parallel with the regularization of feeding behavior. They also mention that the main aim of the intervention is the improvement of daily rhythm and eating, rethinking the way meals are taking place and the way conflicts arise (type and quantity of food offered, eating together at the table, etc.), but the psychologist indicates that all this will be discussed in more detail at the next session.

In the third session, the parents express their honest concern that some things (e.g. giving up “snacks” completely) will be difficult for them, because they feel sorry for Zalán and fear that he will stay hungry all the time and will develop even less. Nevertheless, after they receive sensitive support, educational discussion of the issues and the necessary interventions, they commit themselves to go ahead. Zalán is still actively playing, searching and finding, coming and going around the room, often contacting the psychologist, who responds kindly to his initiatives. Often the father plays with Zalán or runs after him so that he doesn't do something silly while the mother is talking. Zalán's speech has not yet started to really take on, as he mainly uses non-verbal communication to let his environment know what he wants. Speech development delays are also discussed, and the psychologist explains that active chewing helps to initiate articulation and productive speech, and that speech delays are a common co-occurring difficulty in feeding disorders. The psychologist recommends that after the age of two, it is also worth contacting the local early development center for help with this problem.

Parents report that, although they have some concerns, they have already made progress after the first two sessions:

- They stopped leaving around so many snacks, sweet tea, and juice in the house. They administer appetite stimulating drops. They feel that Zalán's appetite is better at 'proper' meals. Although Zalán has found the change difficult to accept, they mix the calorie-rich formula with his evening formula, which he now eats. He does indeed wake up less often at night, which surprises them. “Maybe that is when he was really hungry, poor thing,” says the mother.
- The parents have changed their eating arrangements, eating together more often (all main meals with mom, dinner with dad) from the same 'grown-up' plate, with Zalán helping to set the table, choose and prepare the food. He eats more from his own plate and sometimes asks for his parents' too. He seems to continue to eat well

at the nursery (“Maybe everyone eats together there, he sees the others,” says the father). Lately, he has also accepted several new types of food.

- He has gained half a kilo in a month, which they are both very happy about. They are confident.

The psychologist confirms their efforts and common successes so far, and then goes through the Chatoor symptom list and other recommendations for improving feeding-eating in detail with the parents. Once again they agree that, beside taking into account and accepting Zalán's active, neurologically heightened, and always externally stimulus-oriented nature, the aim is to teach him to recognize the internal hunger-satiety cycle and to eat more food at regular, main meals, rather than continually taking small bites to satisfy his minimal hunger. This requires that they have regular, predictable mealtimes together, with flexible but predictable rules (e.g. sitting at the table and eating for a sufficient amount of time, 'food time' followed by play and all other activities). The mother expresses that she finds it hardest when she cannot give whatever and however much food she wants immediately, that she finds it hard to take 3-4 hour breaks, and that she is not always sure that she will be hungry when it is time for Zalán to eat. The psychologist confirms the possible solutions to avoid these problems that parents come up with, and also stresses the importance of a “contract” and constant conversation with the child about what, when and how they will do it and how Zalán can help. Since they measure the child's weight daily, the psychologist asks parents to weigh only every two weeks before coming for consultations, to which the mother adds with a smile, “yes, I know, so as not to get involved, like with tiny babies”. The psychologist asks the parents to collect Zalán's favorite foods at home in collaboration with the child, as it is these foods that should be used to encourage sharing meals. They say goodbye with the father saying: “We need a solution to this constant misbehavior. Everything is the way he wants it”. They leave the meeting with confidence, knowing that they will be able to talk about this at the next meeting.

Before the fourth appointment, the mother calls to say that she has an inflammation of varicose veins, can hardly walk, and has to lie down, so they cannot attend the consultation. The psychologist consults briefly on the phone and indicates that if they cannot attend the next few weeks because of her illness, they should definitely consult by phone about how they are doing and how the goals they have discussed are going. At the dietician's advice and request, the psychologist indicates to the mother (transdisciplinary knowledge) that the nutrient ratios in the diet should also be changed, as there is too much protein, too little carbohydrate and fat intake, and the child hardly eats any fruit and vegetables. Together, they collect foods from the list already requested that could meet this need, and which Zalán likes. The mother says that in the last few weeks they have been trying many of the things that were discussed in the consultations (longer intervals between meals, no snacks, no juice, formula during the day, mostly eating together, creative exploration of food instead of distracting games

and TV, etc.). With a smile, the mother notes that "I can even put up with him messing around with the food he is served"). Some things work, some don't, but she says she knows it takes patience, and for them it is important that Zalán has put on another 300g. The psychologist confirms the mother that all this takes time. He/she asks the mother to ask the healthy father to visit her next time to report on the progress, even if the whole family cannot. The mother confirms that the father can come.

At *the fifth appointment,* only the father shows up, reports on developments at home: Zalán is slowly but steadily gaining weight, there are fewer fights over meals, but Zalán's "willfulness sometimes makes us fed up" says the father. The psychologist talks to the father not only about feeding, but also about cooperation in other situations and, in general, about setting up a framework to ensure a sense of security for young children, and about the possibilities and importance of setting boundaries (sensitive discipline). The father hands over a short list that the mother and Zalán made together of what Zalán likes to eat and what he "hates". There is also a small drawing on the paper that Zalán made: "cocoa roll". The psychologist asks the father to share what was said during the consultation with the mother.

Interruption of the process. Usually, families of children with infantile anorexia are looking into a long-term cooperation, because the symptoms are often resistant. The development of healthy and pleasurable eating behavior develops gradually due to the children's habitude and the deep lying beliefs and "eating scripts" of the parents. The intervention process cannot be expected to be completed until significant improvements in nutrient intake and weight gain are achieved. In our case, after the fifth session, the mother continued to suffer an inflammation of varicose veins for weeks and then had to undergo surgery necessitating several weeks of rest. In the psychologist's opinion at the time, the consultation should have taken place at least 5 or 6 more times, and regular medical check-ups should have been carried out after that. Other interventions planned during the psychological process included a video recording of the meals taken together, their analysis with the parents, the observation of feeding during the consultation, immediate reinforcing feedback, observation and discussion of interactions other than feeding, discussion of other problems brought by the parents (tensions in the family, disciplinary situations). The psychologist had a few more telephone consultations with the parents, who reported that Zalán had started to eat better and more predictably and experienced some gain weight (1.3 kg in 12 weeks since the first meeting). This was due to the syrups and drops and to doing some things "very differently". With the parents' permission, the specialists also visited the family pediatrician and the nurse, who confirmed that Zalán and his parents were "on track to gain weight". The hospital pediatrician and the district pediatrician agreed to monitor Zalán's progress more closely and to notify the parents immediately of the need for hospitalization if any further stagnation or weight loss was detected. The parents thanked the team for their work and said they would keep in touch with the pediatrician.

The team hypothesized about the sudden interruption of the process. Apparently, the mother's disease and surgery lasted for over a period of weeks, preventing them from coming to the hospital in Budapest from the countryside. They seemed highly motivated from the beginning of the process until the interruption. The external environmental stress may have been a distraction and it may have been difficult for the parents to fully appreciate that the insufficient weight gain had to be considered as a problem even when their child was active, vital, and cheerful. Since the father grew up with the same condition, it might have seemed less of a problem for them. Thirdly, parents tended to use medications, vitamins, other formulae, and age-inappropriate feeding (bottle feeding) rather than behavioral change. The change in food and introduction of appetite stimulating medication may have induced weight gain that the GP and parents were happy with. In the meantime, some behavioral changes had also begun, and the processes were sufficiently effective in the face of the stress associated with the mother's illness that the initial despair had disappeared. They felt more confident about the results achieved so far, which might have been a contributing reason for their suspending to attend consultations.

The case was taken to regular supervision by the psychologist. The factors that may have supported this parenting decision were gathered with the supervising psychologist, and the experience of temporary dissatisfaction and ineffectiveness in the psychologist was also addressed. The psychologist expressed concern, not necessarily trusting that long-term radical improvement would be achieved, as, according to literature, these cases can be managed or maintained through teamwork taking a long period of time. As the GP, in addition to the parents, confirmed that progress was taking the right direction, the parental decision had to be accepted. The collaborative work of the specialists and the GP and the trusting relationship between the family and the GP were the guarantee that with the knowledge, behavioral changes and supplementary nutrients, the child's development and growth would be satisfactory.

Lessons learnt from this case

In the field of pediatrics, in the ward and during outpatient care, interdisciplinary teamwork is the most effective way to address early childhood somatic and behavioral problems. The psychologist usually takes a role in assessing the psychosocial environment and behavior, and then becomes a key player in the treatment by supporting emotion regulation and behavior, parenting, parent-child relationship and family functioning.

4. Discussion

Several theoretical and practical problems have been illustrated in the case study presented in this chapter. The result of paradigm shifts in medicine (i.e. the move away from the biomedical model) are also reflected in practice. Acceptance of the complex etiology of diseases and disorders, as well as systemic, family-centered and biopsychosocial thinking, are now essential in the identification of the causes of disease and in the planning of treatment in many fields including pediatrics. It is especially important in infancy and early childhood. The doctors involved in the case clearly adopted a psychosomatic approach, assuming body-mind-environment interactions in both directions: cause-effect and the repercussions of the problems on the individual mental state and the immediate environment.

Environmental stress as a central risk factor in the development and maintenance of disease was an important theme in our case. The question is: to what extent does a stressful life event contribute to processes in families living in already difficult circumstances? We can imagine the effects and development of stress in terms of a continuous two-way transactional interaction, as stress can cause or sustain illness over time, or the development of illness can increase the daily stress experienced, as the child's symptoms cause anxiety in the parents. This cycle can be acute or chronic.

In addition to the stress factors that are clearly risk factors, the availability and mobilization of peer support, the structure of the peer network and satisfaction with it are key to the protective process. In our case, we can highlight the role of the supportive family and the key people in the mesosystem, in this case the health care system.

The case also contributes to our understanding of models of illness experience and behavior, the doctor-psychologist-patient (child and family) relationship, and the development of compliance and adherence by parents in early childhood: in our case, the team had to formulate explanations and hypotheses for the sudden interruption of the process. In pediatrics, parents are the ones who decide on the treatment of the child, and their cooperation is therefore indispensable for the effective treatment of the child.

The environmental psychological and the doctor-patient relationship aspects of the hospital and the outpatient clinic as a setting strongly influence what the hours and days spent in the hospital or the clinic are like for a young child. Child- and family-friendly spaces and ways of working are essential for effective healthcare. There are large individual and age differences in how children think about and adapt to being in hospital. The importance of a supportive environment cannot be over-emphasized, but for children it is particularly important that parents/primary caregivers are a constant presence in the process. The younger the child, the more important this is.

Inter- and sometimes trans-disciplinary teamwork in care is now increasingly common in many areas of pediatric care in Hungary. The infrastructural and financial framework for the establishment of pediatric psychology is not yet in place, but international and national good practices are available to enable clinical health psychologists to become permanent team members in pediatric care in the near future.

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