Behavioral Medicine in Family Practice: A Unifying Approach for the Assessment and Treatment of Psychosocial Problems

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Assessment and treatment of the varied psychosocial problems which affect patient health often present primary care physicians with their most difficult and frustrating problems. This paper outlines criteria which can be used to select a model of psychosocial treatment compatible with an active family practice clinic. It also describes one treatment model which fits the criteria and can be used to assess and treat a wide range of psychosocial problems common to family practice.

• Barry B., aged 11, referred by his teacher for "hyperkinesis" and "aggression."

• Nancy H., aged 44, complains of "back pain" and "loneliness."

• John R., aged 51, 74 pounds overweight, doesn't take his propranolol with much consistency, and smokes two packs of cigarettes a day.

• Minna Q., aged 84, dying of lung cancer, wants to "go home to her children," but they're afraid they "can't handle it."

• Jeff P., aged 32, a master carpenter, recovering from second and third degree burns on his hands and legs, says he wants to "give up."

• Jill L., aged 38, has alcohol on her breath when she comes in for her regular Papanicolaou smear and pelvic examination.

• Cathy L., aged 24, says her children are "driving her crazy" as she breaks into tears.

So much for part of the day in the life of a family physician. An overdramatization? Psychiatric nightmare? These problems of daily living are often more the facts of family practice than its fictions. Statistically, they represent a major group of presenting problems in any primary care clinic—those which are either essentially psychosocial or are exacerbated by psychosocial varia-

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bles. It is estimated that these sorts of problems constitute 45 percent of all problems presented to physicians.[1] Some place the figures even higher. Whether one takes a conservative, liberal, or radical stance to data interpretation, one fact is common: a substantial percentage of effective family practice is the ability to assess and treat a variety of psychosocial problems which affect personal well-being. Family medicine has taken for one of its responsibilities the medical assessment and treatment of the whole person within the context of the family. With that decision has come the problem of how to effectively diagnose and manage common "people problems." But which theory or system of assessment does a family physician use as a problem-solving vehicle? And further, which system or systems do family practice educators incorporate into a residency program?

At first glance, these may seem like simple questions to answer, especially with the proliferation of theories and therapeutic procedures which purport to explain human behavior and/or alleviate emotional problems. However, it is the very proliferation of theories—the quantity of choices—which makes the questions difficult to answer. Psychoanalysis, transactional analysis, gestalt therapy, client-centered therapy, rational-emotive therapy, primal therapy—each have a unique perspective on the analysis and treatment of human behavior. Which one is right? Or, stated more accurately, which one is right for family practice?

There is at least one major assumption in the question, namely that there *is* one "right" system for psychosocial assessment and treatment in family practice. ("Right" in this context is defined as the most efficient and effective.) Singling out one particular theoretical model does not necessarily mean the others must be excluded or not offered in a curriculum. It does mean, however, that we may be able to find one model which is more appropriate for a family physician to master by the end of a residency. The goal of this paper is to answer the question: Which model of psychosocial assessment and treatment is appropriate for family practice? It is hoped the answer will emerge from addressing four main objectives:

1. To list criteria which could be used to select an appropriate treatment modality.
2. To outline one theoretical and practice model for the diagnosis and treatment of psychosocial problems which meets the criteria.
3. To demonstrate the utility of the model in family practice.
4. To argue for the inclusion of the model in the curriculum of family practice residency programs.

Selection Criteria

To be useful, any theoretical model, no matter how creative or apparently valid, must eventually be translated into practice. Practice settings are constrained by such variables as available treatment time, space, and personnel. This means that the selection of a theoretical model cannot rest simply on the "truth value" of the theory *per se*. Even if, at the extreme, a theoretical model of psychosocial assessment and treatment is valid, if it is not compatible with the limitations and demands of an office-based primary care practice, its "truth value" may be relevant for academic discussion but not for patient care in family practice.

In reflecting on the structural limitations and patient needs in family practice and the educational demands of a residency curriculum, five major criteria emerge which should be used as an initial yardstick in measuring the practice "fit" of any psychosocial theoretical model: (a) practice time available, (b) the comprehensiveness of the model to treat a wide range of presenting problems, (c) compatibility with scientific methodology, (d) demonstrated positive outcome, and (e) the time required to train-to-competency.

Practice Time Available

Whichever theoretical model is selected, it should be suited to the practitioner who must accumulate the most relevant diagnostic and treat-

ment information available within the time allotted in a busy clinic setting. Realistically, then, how much time does a family physician have to spend with any one patient or family during the course of regular clinic hours? Physicians in the Madison, Wisconsin area cite 15 to 20 minutes as the average length of time for a regular clinic visit. Only the most foolhardy would claim that the majority of psychosocial problems can be solved in 15 to 20 minutes. Fortunately, solutions are found outside the office. The primary care practitioner, whether physician, nurse, or social worker, uses available treatment time to help the patient develop management plans. The methodology for change is developed in the office, but the actual attempt to change usually takes place outside the office in the "real world." Few family physicians can afford to give many "50 minute" counseling hours during the course of a day. However, some psychosocial treatment modalities consider extended practitioner (therapist) contact essential for assessment and treatment. Classical psychoanalysis is perhaps the most vivid example. Patients meet with their therapist anywhere from three to five days per week in one hour sessions over the course of several years. If a family physician or health-care team wants to treat the psychosocial problems which affect the patients' health, then availability and the amount of practice time required to achieve successful outcome are important variables to consider in selecting a treatment modality.

Referral to other specialists such as psychiatric services or county mental health agencies would, of course, reduce the actual constraint imposed by this criteria. Hiring specialists (psychologists, social workers) on a fee-for-service basis to work within the primary care clinic might also reduce this constraint. However, in many primary care practices, especially in rural areas, the referral option is virtually impossible because of other constraining variables, such as distance or social sanctions against "psychotherapy." There are indications that the fee-for-service option is practical, but only where third-party payers cover services performed by psychologists and social workers.[2]

The Comprehensiveness of the Model

Since a wide range of personal problems are presented in family practice, the psychosocial model should be broadly based, so that it may be generalized across many different problem areas. Any intervention model, like any drug, has maximum efficiency when it can be used to treat effectively a variety of problems. For instance, it would be more efficient if the model incorporated similar procedures for treating a range of problems from depression to sexual dysfunction to weight control to noncompliance with medication. Psychosocial treatment models, however, are more or less limited in scope. A client-centered therapeutic intervention, for example, may help individuals feel better about themselves but it may not help them overcome their extreme fear of heights or needles. A gestalt intervention may help a person become aware of and express his/her feelings in a more straightforward manner, but it may not necessarily cure premature ejaculation. Psychoanalytic approaches may over the long run help a diabetic person understand his past and his current resistance to intrusive medical procedures, but it may not help him take his medication with any more consistency or help him overcome present marital problems. In selecting psychosocial treatment models appropriate for family practice, focus should be placed on the comprehensiveness or utility of the model across many different problem types. This is not to say that one model will do all things for all people. However, it is saying that among the many models available, selection should focus on broadly based models.

Scientific Compatibility

The cornerstone of the medical model, namely the scientific method, has been largely ignored in the development of psychosocial theories of behavior. Empirically verifiable realities gave way to

creative interpretations of abstract realities (eg, castration complex, oedipal complex, id). Overt behavioral events were interpreted as manifestations or symptoms of an underlying cause, but that cause was not specified concretely enough to permit controlled experimental investigation. To be consistent with a scientific method, empirically verifiable hypotheses need to be formulated and systematically tested. Why insist on scientific method in the first place? The major reason is its built-in accountability.

Scientific investigation is a self-corrective process. Unpredicted results force a reexamination of the data and a reformulation of the hypotheses. More importantly, unpredicted results force a reevaluation of the theory upon which the selected treatments are based. This self-corrective feature builds accountability into the fabric of any empirically based theoretical model. It provides an inherent guarantee that treatment methods based on the theory will not persist simply because they are traditionally practiced. Rather, they will persist because they produce demonstrated effectiveness. Empirical investigation exposes "accumulated practice wisdom" to the rigors of scientific analysis. At the very least, any selected psychosocial model of treatment should "work," but scientists and educators should be able to understand and demonstrate why it works.

Demonstrated Positive Outcome

While this selection criterion may initially seem obvious, it is the one which is usually neglected in psychosocial treatment. It is only within the past 15 years that any systematic clinical research has been done on the outcomes of models of psychotherapy or counseling. Anecdotal reporting has, and still does, constitute the major outcome evaluation criteria. In terms of its potential effect on patients' lives, outcome testing may be as important for psychosocial "effectiveness claims" as it is for drug claims. Unless a psychosocial procedure can demonstrate positive outcome under controlled conditions, reports of its curative value are placebo, at best.

Training-To-Competency

The amount of time it takes to train someone to a minimum level of competency should also be a consideration in any selection process. If two different models of psychosocial treatment are equally effective but mastery of the procedures in one model takes three years while the other takes only three months, the later model should probably be selected if training time is limited—as it is in any family practice residency.

While other criteria may play a role in guiding the selection of a psychosocial treatment model for family practice, the above five seem to stand out as major variables. These evaluation criteria can be used to assess the merits of any psychosocial theory or treatment model. Establishing the criteria will, of course, bias the selection process. Only a limited number of psychosocial theories and treatment models, for instance, are empirically based. One such currently popular psychosocial model will now be outlined and measured against the criteria.

Behavioral Medicine Model

In the 1960s, prompted by the growing body of research on animal learning conducted by Pavlov[3] and Skinner,[4] mental health practitioners, predominantly in institutional settings, began to observe human behavior without using abstract interpretations to ascribe meaning or causes to the behavior.[5] They discovered that many human responses, both normal and abnormal, were predictable based on an analysis of *current* environmental factors. One of the first clinical demonstrations of this type of analysis is worth noting.[6] An institutionalized woman was observed pacing around the ward with a broom, aggressively fending off any attempt to remove her prized possession. Two psychiatrists were asked to analyze her behaviors. Her aggressive broom-holding was subsequently interpreted as a child that gives her love, "a phallic symbol," and "scepter of an omnipotent queen!" However, if current overt environmental events had been observed, the cause of her behaviors would have been clear. She clung to her broom not because of obsessive urges or a

desire to incorporate a phallic symbol, but because she was given cigarettes *only* if she was observed carrying a broom! These early admittedly somewhat unconvincing "experiments" have become increasingly more sophisticated and correspondingly more convincing.[7] The theory used by these practitioners is learning theory and the techniques based on the theory commonly called "behavior modification." Behavioral medicine then refers to any procedure or set of procedures based on learning theory which is used to assess and treat medical or medically related problems.*

"Behavior modification" is not really an accurate term since any human encounter has the potential for affecting and modifying behavior. Also, the term conjures up images of robotized manipulation, parentalism, and an unethical assault on human freedom and dignity. Separated from "bad press," behavior modification and its theoretical underpinning, learning theory, simply states that much of human behavior, adaptive or maladaptive, normal or abnormal, is learned in similar and discoverable ways. Learning theory holds that current maladaptive behaviors, whether they are classified as over-eating, not taking medication, spontaneous and excessive crying, cigarette smoking, or bizarre mannerisms are maintained not by past events buried deep in the unconscious but by current events which can be observed. Maladaptive response patterns might have originated in an early childhood event but the current responses are maintained because of current environmental conditions. If a person's responses are viewed as learned, then they can be unlearned through systematic *training* procedures. The behavioral model of psychosocial treatment is essentially an *educational* model, not a traditional "therapy" model of intervention. Recently, medical literature has been peppered by articles describing the use of behavioral interventions in treating a variety of medically related problems.[8]

The scope of this paper will not allow more than a brief overview of the assessment and treatment procedures used in a behavioral model. More detailed explanations of learning theory and behavioral procedures can be found elsewhere.[7,9-12]

Essentially, a behaviorally oriented practitioner views the patient's psychosocial presenting problems as a combination of behavior (or skill) deficits or excesses. For example, in terms of specific behavior, a child who presents with enuresis is probably wetting too much away from the toilet. The child may not have learned to hold sufficient quantities of urine for extended periods or to sit on the toilet or to tell her parent she has to "go potty" or to wake up when the bladder is filled to capacity. These are all skill deficits which must be learned for the child to stay dry. On the other hand, some people present with behavior of excesses—they eat too much, drink too much, smoke too much, worry too much.

Most psychosocial problems have behavioral correlates, ie, those behaviors or sets of behaviors which are labeled "anxiety," "depression," and "manipulation." A term like "depression," however, does not describe specific problems vis-a-vis *this* patient. It is an abstract construct that summarizes a wide range of possible dysfunctions including indecisiveness, decreased sexual activity, loss of appetite, negative self-statements, and suicidal wishes. An operational description of "depression" for *this* particular patient may be: Mr. Jones sits in his living room for extended periods, crying and refusing to participate in family activities. He is unable to sleep without medication. His conversations include frequent statements of self-blame and hopelessness. Reformulation of the problem into behavioral or operational terms supplies an initial data base for psychosocial treatment and indicates specific goals for Mr. Jones to achieve. For example, he will probably not be labeled depressed if he increases his verbal and physical interactions with family members, decreases excessive crying, sleeps through the night without medication, and increases self-praising or coping statements.

Once a problem has been defined operationally, the first set of assessment questions is raised: What prerequisite skills must *this* person acquire before the goal behavior is achieved? Further, what factors in the environment function to maintain the skill deficit or excess and/or prevent the person from learning the prerequisite skills? Before a child is successfully "potty-trained," for instance, he/she must learn to acquire a series of prerequisite skills: muscle control, walking to the

*Unfortunately, the term behavioral medicine is used broadly to refer to *any* intervention by medical personnel in their treatment of nonorganically based psychosocial problems. I consider this meaning too general and therefore choose to restrict its meaning for the sake of clarity.

toilet, sitting on the toilet seat, and perhaps telling parent she "has to go." Similarly, Mr. Jones must be able to initiate and maintain conversations on various topics of mutual interest in order to interact for extended periods with his family. He may also need to acquire new work skills in order to apply for a more "meaningful job."

These are all skills or behaviors which can be taught in a systematic and deliberate way. To discover which environmental factors are currently maintaining a problem, a behaviorally oriented practitioner performs a *functional analysis.* Events which precede and follow any given behavior are described. This can be done through direct observation, by interview, or by patient/family data collection. Behaviors are assumed to be under *stimulus control* and/or *contingency management.* Behaviors which are under stimulus control have a high probability of occurring when certain events precede them, eg, the sight of an ashtray, another person smoking, or a sip of coffee will often "cue" a smoker to light up. Behaviors maintained by contingencies are shaped and maintained by events which follow them, eg, each time Mr. Brown complains of a headache, his wife ceases her nagging, gets his medication, and asks if there's anything she can do to help him. There is a high probability that Mr. Brown will continue to have headaches. Similarily, if Mrs. Brown is criticized each time she attempts to make an assertive response, there's a good chance that her recent assertiveness training will not help her become more assertive. Consequent events which increase the probability of responses are called *reinforcers;* consequent events which decrease the probability of responses are called *punishers.* It is important to note that punishers and reinforcers are not qualitative aspects of events per se. Spouse nagging, parental spankings, even physician cajoling can be defined as either reinforcers or punishers depending upon the subsequent occurrence of the preceding behavior. It is ironic that many physicians and health-care professionals inadvertently reinforce patient noncompliance through prodding or excessive criticism.

Once the problem behavior is described and controlling environmental milieu identified, a variety of techniques based on learning theory can be used to teach the patient to exhibit more appropriate and health-producing behaviors. Some of the procedures and techniques include: shaping and modeling,[13] systematic desensitization,[14] biofeedback,[15,16] and assertive training.[17] The procedures used may each be "packaged" in slightly different ways but they are all based on social and/or cognitive learning theory principles which can be mastered within relatively short periods of time.

Residents, nurses, and social work students who participate in the behavioral training seminars at the University of Wisconsin Department of Family Medicine and Practice have learned to conduct successful behavioral assessments and treatments of complex cases (more than three interrelated presenting problems) within their first six months of residency. This is not to say that behavioral assessment and treatment is easy. It is as complex, subtle, and intellectually demanding as any psychosocial intervention which purports to treat the "whole person." However, because the principles of behavioral treatment are empirically based and operationally described, they can be learned within relatively short periods. As with any medical procedure, the practitioner of behavioral medicine becomes more skillful with experience. The language of learning theory is straightforward, unpoetic, concrete, devoid of esoteric words and phrases. It does not present the learner with mind-teasing interpretations which take months and much discussion to unravel. Within the past year, residents who have participated in 8 to 12 hours of behavioral training have successfully treated the following types of cases using behavioral procedures: persistent vomiting in an eight-month-old infant; primary orgasmic dysfunction; enuresis; encopresis; headaches; severe temper tantrums; marital conflict; and reactive depression. Some of the cases required assistance from others in the health-care team (nurse, social worker, secretary, receptionist) during the initial stages of treatment, but in all cases the residents understood what procedures would and should be used to increase the probability of success. They could monitor case treatments and, more importantly, understand the rationale for the management plan. Psychosocial or psychiatric treatment need not be a mysterious process but a systematic training procedure toward measurable goals.

While behavioral treatments are not 100 percent effective all of the time, they have demonstrated successful outcome with a range of health related problems including enuresis,[18-21] encopresis,[22-24]

depression,[25-27] smoking,[28] obesity,[29-30] sexual dysfunction,[31] and chronic pain.[32] As such, behavioral medicine is comprehensive, covering many different types of psychosocial problem areas. The strategies used in the different areas are based on principles of social and cognitive learning theory *tailored to each different patient and problem type.*

Data gathering in a behavioral model is efficient since the practitioner knows ahead of time the types of questions to ask which will elicit the relevant environmental information about antecedent and consequent events.[33] The 20-minute office visit, then, can often be sufficient to gather enough data to formulate an initial management plan. When more extensive time is required for assessment, the physician can refer to another member of the health-care team after the first 20-minute visit with specific guidelines for those interviews. Literature and clinical experience in the Department of Family Medicine and Practice at the University of Wisconsin, Madison, indicates that many behavior treatments tend to succeed in relatively short time periods, ie, from one to six months.

Behavioral Medicine as Prevention

Because the behavioral model looks at prerequisite skills in an environmental context, it can also be considered a preventively oriented approach to practice. A family physician has an opportunity to see patients over an extended time period. At each health assessment or problem visit, the physician or nurse can focus on the behavioral skills (personal, interpersonal, and social) needed by the patient at his/her stage of development and determine whether or not the environment is structured to facilitate learning those skills. For instance, Johnny, aged 14, is quite shy, ie, he looks down at the ground when someone talks with him, blushes, gives one or two-word responses to questions and rarely initiates any conversations when he is in the office. After brief interviewing, the physician discovers that Johnny is not just that way with him but with most adults and some peers. Behavioral procedures such as assertiveness training may help Johnny establish eye-contact while someone is speaking to him, and may help him initiate and maintain conversations. This kind of training may also help to decrease frequent blushing! Similarily, a couple experiencing their first pregnancy needs to learn a range of child management skills. Management skills based on social learning theory can be taught in brief time periods during monthly prenatal visits.[34] If a person's personality is conceptualized as a package of discrete behaviors which can be learned, relearned, and unlearned, then personality change is always a potential possibility. If nothing else, this view of human behavior may help maintain the optimism of a practitioner who has just seen the tenth depressed patient of the morning.

As outlined, the behavioral model of psychosocial assessment and treatment fulfills the criteria established at the outset of this paper. It is empirically based, has been demonstrated effective with a wide range of problems commonly seen in family practice settings, can be incorporated into the time demands of a busy practice, and can be taught in a relatively brief time. Incorporating the behavioral model into a family practice residency curriculum may help to give residents both a perceived *and* a real competency to assess and treat the difficult and most frequent psychosocial problems they will face as family physicians.

Since 1975, the Department of Family Medicine and Practice at the University of Wisconsin has incorporated behavioral medicine training into its behavioral science curriculum. Aside from didactic seminars, the residents also work with behavioral clinicians who staff each of the model clinics in the program. Behavioral medicine is incorporated both as an educational and a service component of the residency. Evaluating the effectiveness of this kind of training is in its beginning stages. However, there are already preliminary indications that residents who are trained in behavioral medicine not only identify more psychosocial variables but systematically integrate them into corrective treatment plans.* Behavioral medicine is certainly not a panacea for psychosocial problems, but it currently stands as the prime candidate for psychosocial assessment and treatment in family practice.

*Brockway B: Evaluating physician competency: What difference does it make? (unpublished paper, November 1977)

References

1. Starfield B, Borkowf S: Physician's recognition of complaints made by parents about their children's health. Pediatrics 43:170, 1969

2. Brockway B, Werking J, Fitzgibbons K, et al: Social work in the doctor's office. In Ross B, Khinduka SK (eds): Social Work in Practice. Washington, DC, National Association of Social Workers, 1976

3. Pavlov IP: Conditioned Reflexes. New York, Dover Publications, 1927

4. Skinner BF: Science and Human Behavior. New York, Macmillan, 1953

5. Ullman L, Krasner L: A Psychological Approach to Abnormal Behavior. Englewood Cliffs, New Jersey, Prentice-Hall, 1969

6. Ayllon T, Haughton E, Hughes HB: Interpretations of symptoms: Fact or fiction. Behav Res Ther 3:1, 1965

7. Rimm DC, Masters JC: Behavior Therapy: Techniques and Empirical Findings. New York, Academic Press, 1974

8. Katz R, Zlutnick R: Behavior Therapy and Health Care: Principles and Applications. New York, Pergamon Press, 1975

9. Whaley D, Mallott R: Elementary Principles of Behavior. New York, Appleton-Century-Crofts, 1971

10. Tharp RG, Wetzel RJ: Behavior Modification in the Natural Environment. New York, Academic Press, 1969

11. Bandura A: Principles of Behavior Modification. New York, Holt, Rinehart, Winston, 1969

12. Mahoney M: Cognition and Behavior Modification. Cambridge, Massachusetts, Ballinger, 1974

13. Whaley D, Mallott R: Elementary Principles of Behavior. New York, Appleton-Century-Crofts, 1971

14. Wolpe J: The Practice of Behavior Therapy. New York, Pergamon Press, 1967

15. Budzynski TH, Stoyva JM: An instrument for producing deep muscle relaxation by means of analogue information feedback. J Appl Behav Anal 2:231, 1969

16. Weiss T, Engel BT: Operant conditioning of heart rate in patients with premature ventricular contractions. Psychosom Med 33:301, 1971

17. Alberti RE, Emmons MD: Your Perfect Right! San Luis Obispo, California, Impact, 1970

18. Turner RK, Young GC: CNS stimulant drugs and conditioning treatment of nocturnal enuresis: A long-term follow-up study. Behav Res Ther 4:225, 1966

19. Young GC, Morgan RT: Overlearning in the conditioning treatment of enuresis: A long-term follow-up study. Behav Res Ther 10:419, 1972

20. Delcon G, Sacks S: Conditioning functional enuresis: A four-year follow-up. J Consult Clin Psychol 39:299, 1972

21. Paschalis A, Kimmel HD, Kimmel E: Further study of diurnal instrumental conditioning in the treatment of enuresis nocturna. J Behav Ther Exp Psychiatr 3:253, 1972

22. Neale DH: Behavior therapy and encopresis in children. Behav Res Ther 1:139-149, 1963

23. Lal H, Lindsley OR: Therapy of chronic constipation in a young child by rearranging social contingencies. Behav Res Ther 6:484, 1968

24. Edleman RI: Operant conditioning treatment of encopresis. J Behav Ther Exp Psychiatr 1:71, 1971

25. Liberman RP, Raskin DE: Depression: A behavioral formulation. Arch Gen Psychiatr 24:515, 1971

26. Lazarus A: Multimodal behavioral treatment of depression. Behav Ther 5:549, 1974

27. Seligman M: Helplessness. San Francisco, Freeman, 1975

28. Brockway B, Kleinmann G, Edleson J, et al: Nonaversive procedures and their affect on cigarette smoking. Addictive Behav 2:121, 1977

29. Penick SB, Filion R, Fox S, et al: Behavior modification in the treatment of obesity. Psychosom Med 33:49, 1971

30. Mahoney M, Mahoney K: Permanent Weight Control. New York, Norton, 1976

31. Lobitz WC, LoPiccolo J: New methods in the behavioral treatment of sexual dysfunction. J Behav Ther Exp Psychiatr 3:265, 1972

32. Fordyce W, Fowler R, Lehman J, et al: Some implications of learning in problems of chronic pain. J Chronic Dis 21:179, 1968

33. Hersen M, Bellack A: Behavioral Assessment: A Practical Handbook. New York, Pergamon Press, 1976

34. Brockway B: Training in Child Management: A Family Approach. Dubuque, Iowa, Kendall/Hunt, 1974