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PRIMARY CARE:
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Preface

Donald E. Greydanus, MD Helen D. Pratt, PhD Dilip R. Patel, MD
Guest Editors

> The boundary between biology and behavior is arbitrary and changing. It has been imposed not by the natural contours of disciplines but by lack of knowledge.
>
> —Kandel [1]

Our children have many complex challenges as they go through a myriad of developmental phases from birth and infancy (ab incunabulis) to adulthood. Parents often turn to their primary care clinician when behavioral problems arise and they also expect that their family doctor will identify the problems parents cannot yet comprehend. Indeed, many pediatric patients in these offices have either nonmedical (ie, behavioral) dilemmas or have medical problems complicated by behavioral influences [2,3]. Behavioral Pediatrics has been defined as "what the clinician does to diagnose, to treat, and most importantly, to *prevent* mental illness in children and adolescents" [4]. The term was derived in the early 1970s by Dr. Robert Haggerty and his colleagues at the University of Rochester (Rochester, New York) who were looking at mental health problems of children from the viewpoint of non-psychiatrists [4]. Dr. Stanford Friedman defined Behavioral Pediatrics as a field "...which focuses on the psychological, social, and learning problems of children and adolescents" [5].

It was in the nineteenth century that specific attention was focused on children (versus adults) based on the then gradually emerging concept that children were not simply small adults and thus needed separate study regarding their health [6]. Before the twentieth century, clinicians dealing with children were focusing on preventing morbidity and mortality from

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uncontrollable infections [7–10]. Advancements in pediatric infectious diseases in the twentieth and the twenty-first centuries have allowed clinicians more opportunity to deal with other issues, including the mental health of these children and adolescents. More impetus was developed by the unfolding of child psychiatry in the 1920s and 1930s, the emergence of family therapy as a management tool in the 1950s, and the advancement of psychopharmacology for all ages in the latter part of the twentieth century [2,3]. The major shortage of child psychiatrists and other mental heath specialists who are available to deal with emotional disorders in children and adolescents has required increased attention to these issues from primary care clinicians.

The twenty-first century view of child development has emerged from the nineteenth and twentieth century models of evolution (with Charles Darwin), the organismic model (with Jean Piaget and G. Stanley Hall), the psychoanalytic model (with Sigmund Freud), the mechanistic model (with B.F. Skinner), and the contextualistic model (with William James) [2,3]. The proposed link between mental health and criminal behavior began centuries ago and only now is slowly receding. Perhaps the sine qua non of Behavioral Pediatrics is attention-deficit-hyperactivity disorder (ADHD), a condition linked in England in 1902 with "defects of moral control" [11]. Today ADHD is understood as a genetic, neurobehavioral disorder with complex neurotransmitter dysfunction and many emerging subtypes [12].

Research in the neurobiologic model of mental illness has resulted in an explosion of psychopharmacologic agents available to the clinician for management of mental illness in pediatrics, further expanding the realm of behavioral pediatrics [13,14]. Rapidly developing research can also be confusing to those on the front lines of care, however. For example, the recent Food and Drug Administration's warnings linking potential suicidality and the use of antidepressants has led to a decrease by primary care clinicians in the use of these medications [15–17]. More education in these important areas is constantly needed, because translational research with monumental impact on our children occurs in the primary care clinician's office and not just in the laboratory or halls of academia.

It is within this crucial context that our issue of *Primary Care: Clinics in Office Practice* presents a potpourri of articles that fit within the rubric of Behavioral Pediatrics. This issue explores various elements in the wide and fascinating world of pediatric mental illness that present to the primary care clinician. We look at screening tools useful to detect developmental-behavioral problems of children, identify behavioral interventions in childhood with the hope of preventing adult diseases, present methods of teaching self control, and comment on the role of cross-cultural issues in primary care. We also look at classic examples of behavioral pediatrics, such as depression, suicidality, ADHD, autism, learning disorders, and mental retardation (intellectual disability). Every day headlines in the media remind us of the exposure our children have to violence in our society, and thus we

look at psychologic aspects of trauma. This issue also addresses deafness and insomnia. Finally, any discussion of behavioral pediatrics should acknowledge the importance of human sexuality; thus we look at general aspects of childhood sexuality, same-sex attractions, and the adolescent sexual offender.

The editors of this issue are indebted to the many outstanding experts who gave of their valuable time to prepare these articles. We also thank Karen Sorensen for her wonderful professional help and encouragement in the development of this issue on Behavioral Pediatrics. Finally, we sincerely hope that this collection of articles will prove useful to you, the reader of this journal, in your quest to improve the lives of the children and adolescents in your practice. This work is dedicated to you with much respect and admiration (ab imo pectore) for the wonderful work you do every day on the front lines of health care in the United States.

Who loves not knowledge? Who shall rail
Against her beauty? May she mix
With men and prosper! Who shall fix
Her pillars? Let her work prevail.

—*In Memoriam, CXIV,* Tennyson [18]

Donald E. Greydanus, MD
Helen D. Pratt, PhD
Dilip R. Patel, MD
Pediatrics & Human Development
Michigan State University College of Human Medicine
Pediatrics Program
Michigan State University/Kalamazoo Center for Medical Studies
1000 Oakland Drive
Kalamazoo, MI 49008-1284, USA

E-mail address: greydanus@kcms.msu.edu

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