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CHILD PSYCHIATRY FOR THE GENERAL PSYCHIATRIST

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Child Psychiatry for the General Psychiatrist

The professional activities of general psychiatrists will touch upon the lives of children to variable degrees and by different routes. Some may have regular clinical contacts with young patients. The usual work of other practitioners will affect them only indirectly. In this chapter, we shall present some points of view about meeting children's psychiatric needs under the following broad headings:

1. Direct work with children and adolescents in the general psychiatrist's practice.

2. Implications in care of adult patients of the two-way interaction between them and their children, especially with regard to the impact upon the children of psychopathological reactions or states in their families.

3. Opportunities for application of knowledge about growth and development in consultative and collaborative roles.

Though the problems to be solved differ within and among these areas, some basic principles are common to all. (1) The importance of constitution: it is increasingly recognized that the individual traits and potentials which the child brings into the world significantly influence the outcome of particular experiences with it. (2) The dimension of development: the child's responses to his internal and external environment are a function of where he is in his

development; the form of response reflects what is important and available during a certain phase; clinical thinking must attend not only to the current situation but also to effects in the future. (3) The central position of the family: the child is dependent on family members not only physically but emotionally; his attachments to them are of a different order than those of adults; actions on one side of the parent-child relationship have reciprocal effects on the other.

The Child as the Patient

Child psychiatry, as a specialized field with a distinct body of theoretical knowledge and clinical approaches, has gained increasing recognition since the beginning of formal training in the 1920s. In the 1970s about 6 percent of the psychiatrists in the United States are also recognized as specialists in the problems of children. By virtue of variations in distribution, local referral practices, individual interests and public resistance to recognizing emotional disturbance in children until it becomes acute, a large proportion of young children with psychiatric difficulties are first brought to the attention of the general psychiatrist. In addition, adolescents form a "no-man's land" between the areas of expertise and activity of the general psychiatrist and the child psychiatrist. Technical information about diagnostic procedures and therapeutic modalities for children and adolescents can be found in Vol.

Here, we shall touch on certain problems which may confront the practitioner who is consulted about a child in circumstances which make it advisable or even mandatory that he respond himself.

Psychiatric Emergencies

As in other aspects of medicine, first attention is due to whether the child's immediate condition, usually meaning his behavior, poses an imminent threat to himself or others.

Acute conditions which account for the bulk of emergencies in adults are less common in children. Before puberty one rarely sees the acute onset of florid psychotic syndromes with hallucinations or delusions (Robinson, 1961). Psychosis in children is more likely to be noted, often after symptoms have been present for some time, in disturbed relationships, social withdrawal, school failure or bizarre habit patterns. Instead of overt depressive reactions attended by suicidal risk, children are more likely to show *depressive equivalents* in the form of eating or habit disturbances, being *naughty* or running away. Acute brain syndromes related to drug ingestion or withdrawal are apt to be by-products of curiosity, shows of bravado, imitation of parents, or competition with siblings for oral supplies. A careful physical examination should always be performed, with neurological consultation if indicated, since a number of infectious, neoplastic, and metabolic disorders

can initially present in behavioral changes.

A child will usually have given clues to mounting anxiety in conduct disorders, nonspecific emotional upsets and/or adaptive difficulties before an external event puts him in the spotlight. This often entails the parents being faced with a crisis, as when the child exceeds academic or disciplinary tolerance in school, becomes an object of community concern or presents a major obstacle to important family plans or aspirations. Demands upon the psychiatrist for dramatic intervention will then be quite insistent and he should bear in mind the need to understand who is feeling the distress at the moment. This is another way of saying that a symptom's *value* can be measured on a number of scales. The child, too, will be aware, at least on some level, of this fact.

Approach to the child's medical situation must take into account the critical role and participation of parents or their surrogates. The child is not a free agent. His environment has a greater impact upon him than upon most adults. On the positive side, the psychiatrist may thus be able to effect influences upon his patient's behavior which would be impossible with adults, who may have to be hospitalized to achieve the same effects. On the negative side, the child's dependence upon people with whom he lives renders him more vulnerable to them. He is more helpless in the face of physical actions by parents or other caretakers. Also, their great importance

to him for survival in combination with his own immature defenses and coping abilities make him more likely to react in action modes to what they do to him psychologically. An emergency evaluation of a child, therefore, is incomplete without assessment of the likelihood of his milieu's influencing him to bring his behaviors under control or contributing to their persistence and even escalation.

Finally, two key principles which define an emergency are relatively unique to childhood and adolescence. The first is that there will be normal developmental crises (Freud, 1962). Their symptomatic manifestations may he more spectacular and arouse more concern in parents than those of truly fixed psychopathology. At times these upheavals of the status quo may even resolve existing conflicts, though complacency on this score is unwarranted. The second principle also derives from the fact of children's rapid growth and evolution. Any situation which creates a significant hiatus in essential experiences may be disastrous to orderly development. The risk of such a hiatus occurring, irrespective of cause, constitutes a very real emergency and may deserve overriding priority for intervention. For examples, severe under-stimulation and emotional deprivation in the early years; chronic inaccessibility to basic education as a result of learning disabilities or hyperactivity; atypical or absent models for identification and superego formation; and use of consciousness-altering drugs which keep an adolescent from acquiring academic, vocational, or social skills.

Suicide

Youthful suicides have been recorded in almost every culture and have aroused medical comment for more than a century. Incidence has been rising since the 1930s. While rare in the years before adolescence, attempts have been noted by children as young as three years old. There is a peak around age ten and another in the fifteen- to nineteen-year age group, where it ranks among the two or three leading causes of death. Attempts by boys outnumber those by girls until adolescence. The ratio of attempts to successful suicide ranges from 5:1 to 100:1 and may be even higher when covert efforts are taken into account. Parents and authorities tend to conceal or discount its occurrence. A number of children making overt attempts, let alone those with repetitive *accidental* self-injuries, may thus miss receiving needed attention. The general guideline to take all suicidal overtures seriously applies to children as well as to adults. Criteria for assessing *genuineness* of frank attempts are comparable to those used in adults.

Child suicide is characterized by impulsivity, apparently trivial precipitants, and little, if any, planning or premeditation. Since the concept of death undergoes evolution during development, individual children's attempts stem from varying admixtures of magical thinking, efforts at control, and manipulation and direction of hostile impulses against the self (Yacoubian, 1973). Generally, there will already have been disturbances in

fusion of libidinal and aggressive drives with failures of neutralization, inhibition or dilution of the latter. Problems with impulse control, often culturally determined, are thus a significant precondition. While suicidal thoughts and fantasies are almost ubiquitous during childhood and adolescence and can be pleasurable, acting on them is usually rejected as an adaptive device. When the step is taken, the most frequent psychodynamic issues are aggression and escape from an intolerable intrapsychic or external situation. The aggression is most often directed towards a parent or the whole family, though self-punishment for hostile thoughts or forbidden acts such as masturbation is not an uncommon motive. Most children tend to regress under overwhelming or extremely painful circumstances. When the heightened dependency needs go unmet, escape from discouragement, helplessness, or severe threat may then be sought through suicide. Other important dynamic elements include identification with a beloved relative, delusional thinking, and suggestion.

Chronic depression and superego conflicts become a prime factor only after early adolescence, usually in those who are having trouble functioning comfortably in new sexual and social roles because they have not resolved earlier developmental issues. Difficulties in making the transition from home to community can be based on discrepant values, constitutional inadaptability, or defensive rigidity. In turn, they can bring on the helplessness, hopelessness, and guilt which the suicide seeks to escape. At

times there may be "external compliance" through reinforcement by parents of a teenager's fantasies of worthlessness and dangerousness. He may come to consider himself *expendable* and see dispensing with himself as a favor to others, whom he yet wishes to please.

Hospitalization is usually indicated, though in some unusual circumstances the necessary medical care and observation may be feasible elsewhere. The patient should be reassured and supported as a child in trouble. If agitation or drug effects indicate restraint, they should be applied for control rather than punishment. Such a protective atmosphere should allow for the beginning of a deeper understanding of the patient's symptomatic distress and the family situation. To be appropriate, psychotherapy should address the immediate emergency, the need for prevention against recurrence, and the patient's long-term needs. Environmental changes, such as reassignment from an excessively stressful academic placement, may be helpful. Involvement of the whole family should be considered, first via crisis intervention techniques and teamwork, and then in an ongoing manner as indicated by their dynamics and ability to come for help after the current crisis passes. An appreciation of the special style and needs of impulsive families (Rexford, 1966) might increase the chances of rendering more definitive treatment.

School Phobia

This relatively common syndrome of early childhood merits attention as an acute psychiatric emergency because of its frank interruption of progress along a number of developmental fronts and because prognosis is so dependent on appropriate early management. Should it become chronic, the phobic pattern of avoidance and regression may be almost irreversible and continue into later life (Eisenberg, 1958). Patients with *work phobia* seen by the general psychiatrist often have genetic and dynamic features in common with school-phobic children.

The point at which psychiatric attention is sought depends on the child's initial symptomatology and the attitudes of physician, parents, and school authorities. Frequently the syndrome begins with complaints during school hours of gastrointestinal upset or malaise for which no organic basis can be found. Trials of indulgence, encouragement, or coercion prove fruitless. Fears related to the classroom, teacher, or playground may be expressed, especially if there has been a frightening or dangerous *real* event. Response through environmental manipulation is rarely successful, however. Even in the absence of overt fears, it becomes evident that the child dreads leaving home and that the family is somehow unable to induce his return to school. Differentiation from truancy is fairly easy: the impulsive or antisocial child dislikes school; he avoids or leaves it in order to pursue pleasures elsewhere; he returns home because of convenience or fear, not anxiety; and he will try to keep his truancy a secret from parents. The phobic child, on the other hand,

is usually motivated to learn, sticks close to home, draws family attention to his problem, and is ashamed to have others know about it.

The significance of this syndrome varies with the child's stage of development and the degree to which it stems from fixed internalized processes. For the otherwise healthy young child confronting the stress of a new situation, it may be due only to expectable and transient separation anxiety. In the adolescent, it may be premonitory of more severe personality disturbances, including psychosis. In the latency child (where incidence in girls is at least as high as in boys), persistent partial or total inability to go to school associated with irrational dread often represents a serious individual and family problem around dependency and aggression. When the psychodynamics of the situation come to be understood, the characteristic picture is of a preexisting, excessively close, child-mother relationship rooted in hostile dependency; an event which threatens the security of both and increases their mutual dependency; a vicious circle of mounting demands, anger, expiatory giving-in, and undoing; and an atmosphere of contradictory verbal and action messages, projection and displacement. The father's role in the dynamic processes, while perhaps indirect, is also important. Parental behavior may clearly foster the child's remaining close, but he himself also cannot leave home because of anxiety about what he might lose or what his unconscious hostility might cause in his absence. Parental violence or a younger sibling's presence adds reality weight to such concerns.

Definitive treatment obviously must address the child and family pathology, which often involves intensive and lengthy psychotherapy. Early return to school must nevertheless take high priority. This step is essential to the child's continued development and for prevention of increasing academic and social handicaps. It also should serve long-term treatment goals by helping to make the unconscious determinants on all sides more accessible. From the outset, management should be a joint physician-family-school undertaking. Detailed step-by-step plans may be needed. The psychotherapeutic approach offers exceptional indications and opportunities for collaboration with the specialist in child psychiatry. The work with the parents, or perhaps mother alone, should be undertaken with the same point of view as the treatment of severely neurotic or borderline adults.

Fire Setting

The emergency nature of this dramatic symptom varies greatly. At one end of the spectrum, it may derive exclusively from the intense concern it understandably generates in the community. At the other end, it may be the signal of significant psychopathology, such as psychosis, antisocial personality disorder, or acute anxiety states. Preschool children, mostly boys, often are impelled by curiosity, imitation, or phallic exhibitionism to set fires which then get out of control. In this age group, but more so in latency, pathological fire setting is usually associated with other manifestations of

poor impulse control, such as rage reactions, hyperactivity, enuresis, cruelty, truancy, or stealing. Severe anxiety and/or learning disabilities may have contributed to poor social adjustment in some children. The fires which preadolescent children tend to set in or near their homes commonly have a psychodynamic meaning related to love, such as revenge on rivals, punishment of ungiving parents, or attention-seeking. In adolescents fire setting has a more ominous import, both in terms of the underlying psychopathology and the danger to others. These patients are more likely to be schizophrenic, mentally retarded, or psychoneurotic with sexual perversions. However, some adolescents without severe personality distortion may resort to this type of behavior as a cry for help with situational or intrapsychic conflicts.

Whatever the age of the child involved, direct management is dictated for his own and the community's welfare. As a rule, the behavior may be expected to be repeated. With some younger children, parents may be able to assume the necessary responsibility for their supervision. Where this is not so, and in the case of adolescents, removal from the home to an institution may be necessary. The choice between an open or closed setting will depend on individual factors, such as the meaning of the symptom, overall reliability of impulse controls, history of premeditation, planning, and seriousness of the incendiarism. A longterm psychotherapeutic approach, attuned to the child's basic condition, will usually be needed. Family participation in conjoint or

collaborative therapy is, of course, essential.

Anorexia Nervosa

Anorexia nervosa, which occurs predominantly in pre- and early adolescent girls, is a symptom constellation centering about severe weight loss, failure of appetite, and unusual attitudes towards food (Gull, 1874). It may begin with bulimia and/or deliberate dieting. Early relationship conflicts, especially about feeding, and body-image problems are generally found. The overall clinical picture may be of a personality disorder of predominantly obsessive-compulsive, hysterical, or schizoid type. This syndrome occurs in psychotic patients as well. The suicidal potential in self-starvation also fits in with the dynamics of children who have suffered losses of important people or self-esteem.

Though long-term psychiatric attention is often necessary, response on an emergency basis is dictated during the first phases of management of the acutely anorectic child and his environment. Here the psychiatrist would function most usefully as a member of the medical treatment team. As the immediate need is to deal with the life-endangering starvation, efforts to manage the patient's nutrition will likely already be underway. The psychiatrist can contribute through a preliminary assessment of whether the particular child-family interaction is conducive to implementing the medical

regimen at home. This will quite often not be likely and, perhaps after a further trial, transfer to hospital will occur. Initial efforts to establish a psychotherapeutic relationship with the patient and family should take place within the context of the team approach. Confident psychiatric diagnosis and prognosis will probably be obscured in the midst of the crises created by the precarious physical situation and the importance of day-to-day management. At this point, an ongoing consultative role for the psychiatrist will help with the intense emotional impact which anorectics have upon those concerned with their care. Their defense of starvation, negativism, and ingenious manipulativeness may arouse in the professional staff anxiety, guilt, and hostility comparable to those which paralyzed the parents. Sustained application of psychiatric insights and skills to the minute details of the patient's dealings with those in his milieu is often required to maintain the team's consistency in being firm and understanding, reestablishing regular eating patterns and limiting destructive interactions with the family.

Direct psychotherapeutic work with the child and parents should begin promptly. It may be enhanced by having them see different therapists who should have regular collaborative meetings. These keep lines of communication open, obviate being manipulated into opposition with other staff, and dilute the potentially interfering countertransference's created by the pressure of their patients' demands (Rollins, 1968). In the first phase of work with the child patient, the therapist aims at providing a positive

relationship, accepting disturbing feelings of hostility and oral greed, helping with controls and giving a sense of protection from an environment viewed as malign. As the need for self-starvation abates and the anxiety level drops, the therapist's focus can enlarge to understanding and working with the underlying psychopathology.

Assaults on Children

The psychiatrist may be called upon to participate in cases of abused, assaulted, or grossly neglected children in his role as a hospital staff member, consultant to social and legal agencies, or private practitioner. His skills in interviewing and knowledge of development and individual and family psychopathology remain the basic tools in making evaluations and decisions about disposition. The special quality of these situations may provide opportunities to help all those involved by also bringing to bear consultative skills, awareness of the complexities of child-family interactions, and appreciation of the long-term sequelae of these emergencies.

The Battered Child

Social and medical alertness to the prevalence (estimated at 10-20 percent of those seen in emergency rooms) of physical abuse or gross neglect of children has risen significantly in recent years (National Conference on Child Abuse, 1974). Physicians have learned to include parent-inflicted

trauma as an etiological possibility in the diagnosis of a range of childhood injuries and illnesses. An increasing number of jurisdictions have made reporting of suspected cases mandatory. All those present in an emergency room may be thus operating under crisis conditions. The onus of legal responsibilities upon the professional staff and their identification with the child victim may skew their approach to examining and interviewing. Parents sensing accusation and danger may conceal medical data, become angrily defensive, be incapacitated by anxiety, or attempt to flee, thereby interfering with the child's care and building up the case against themselves. Later, mandatory legal and social investigations may be carried out in a way which alienates them from sources of help or imperils the family's community standing or financial security. The child may react to the battle he sees (or fantasizes) raging about him with agitation, regression, withdrawal or picking sides. Information he gives should be weighed as well in the light of his expectable cognitive capacities, reality-testing, and attitude toward the truth. Removal of the parents for police interrogation, his own hospitalization for treatment of injuries and psychosocial workup, sometimes with enforced isolation from the family, or even institutional placement pending legal action, will usually be a significant trauma in its own right. The reactions to separation or to the uncertainty of his future may be erroneously ascribed to the original abuse and go inadequately attended.

In fortunate instances, the suspected battered child and family are

offered from the outset the services of an interdisciplinary medical-mental health-social service team. Police and legal involvement is provided in a collaborative spirit by units, e.g., the juvenile squad or the Children's Court clinical staff, trained to reconcile the requirements of justice with those of family rehabilitation and individual emotional needs. Ancillary services, such as day-care centers and innovative psychotherapeutic approaches, are mobilized. Emphasis is on following through with meeting the specific needs of parents and child as they reciprocally influence each other.

The considerable body of descriptive and research studies which has evolved in this field has tended to focus upon the parental side of the interaction. Such data can be useful to the psychiatrist in direct work with parents. While a consistent diagnostic picture has not been found, there is ample evidence of ego and superego distortions and instinctual drive disturbance in the battering parent as well as the silent spouse. Examination of child-rearing patterns reveals not only a frequent repetition of violence experienced in the abuser's own childhood, but a deeper conviction that the child should be punished even during infancy for failing to meet parental needs through proper behavior and gratifying achievement. Sensitive interplay and warm, empathic motherliness outside the mechanical aspects of child care are often significantly lacking. The child may be misperceived as bad, spoiled, sickly, out of control, or a problem in some other way. He may be a disappointment to conscious or unconscious wishes. Specific dynamic

constellations have been described in parents centering on fear of the child's helplessness, seductiveness, or punitiveness. In certain cases it is possible to identify a gross distortion in which a child in a particular stage of development is perceived as a hostile persecutory adult; the assault is thus provoked by such a circumscribed psychotic transference.

The perspective of child psychiatry can add to this category of data a respect for the child's possible contribution to the disturbed relationships which result in his being attacked. Physical abnormalities, conditions of conception, sex, and impact of his birth upon the family's living situation could be obvious factors which feed into existing parental difficulties. A part may also be played by more subtle constitutional qualities, whether the overtaxing of a marginally coping mother by a mentally retarded or hyperthymic infant or the anxiety about intactness raised by one who is quite passive. Characteristics of the infant secondary to maternal deprivation, notably in the area of ego defects, may perpetuate a vicious circle. So could the child's retaliatory behavior, learned during earlier episodes of being attacked or stemming from identification with behavior of family members towards each other.

Sexual Assaults

These include not only forcible rape but also a variety of

overstimulating activities which exceed the child's ability to cope with them. Their impact, therefore, is independent of the degree of willingness or seduction on the child's own part. Effects will depend not only on the circumstances of the act but also on the child's current phase-specific fantasies, ego capacities, and means of handling anxiety (Lewis, 1969). Immediate symptoms will not be pathognomonic of sexual assault. Rather, they will reflect the involvement by' anxiety of the period's major developmental issues. Thus, infants may show disturbed feeding, excretory, or speech functions. Insistent craving for stimulation may appear. In early childhood, there will be habit and conduct disorders, phobic symptoms, sexual idiosyncrasies, or interference with learning. Older children may react with transient neurotic or psychosocial problems.

Psychiatric concern centers about the effects upon the child of a trauma which does not get worked through. The general principle applies that he will attempt to defend against externally caused anxiety by "doing unto others," i.e., becoming the aggressor in repeating the action in which he was originally the passive party. Frank sexual deviation is a possibility in later years.

Acute management should respect the importance of environmental reaction. The child will pick up messages of anxiety, guilt, or accusation from parents and authorities, who should be helped to see his needs objectively. Opportunities should be provided for the child to ventilate and abreact guilt,

anxiety, and feelings of responsibility and to be supported and reassured. Techniques will depend on age and specific conditions. The victim of actual rape will often be in a state of acute fear or even panic. Hysterical symptoms may be present. Medical and other inquiries should be handled so as not to aggravate the problem. Handling at home is desirable, with hospitalization only if the child is a clear suicidal risk or if the parents' inability to manage their own feelings would add further major trauma. The initial phase of "talking things out" is often best done with a friendly, objective person other than a relative. The whole family should also be helped to discuss the assault together to obviate the child's assuming that (s)he is considered bad or to blame. The psychiatrist may find it most useful to act in a consultant role during these steps rather than offering therapy directly to the child and family.

Sexual assaults by close relatives, especially parents, signify disturbed object relationships somewhere in the family. Further follow-up is indicated, including attention to possible compliance or encouragement by the "noninvolved" parent. In cases of assault by others, the best preventive psychiatry may be more careful selection of babysitters (Lourie, 1973).

Other Acute Situations

Anxiety attacks may follow external catastrophes, life stresses, or family

upsets. Great fear, crying, mutism, perseverative speech, or sleep disorders may be seen. Concomitant parental anxiety may contribute to a vicious circle and make the child uncontrollable. Observing him in isolation from the family temporarily may bring relief and help to identify the origins of anxiety-provoking stimuli. It may emerge that the child has been chronically anxious in company with his parents. Appropriate treatment for all should follow.

Children may also react acutely to deaths of parents or other close relatives, though a slower time table is more typical. The precipitant is often panic or decompensation in those around them. Such situations are special because of the excessive guilt often involved. Initial management should therefore stress adequate opportunities for ventilation with an objective professional.

Other children will be overcome by shame or guilt following the injury (or death) of a relative or pet for which they hold their own fantasies responsible. Confusional states, hallucinations, and withdrawal may follow. Admission to a hospital or similar setting may .be necessary to protect the child from his own acting-out. When the crisis abates, he should be evaluated for underlying psychopathology, which frequently will have gone unrecognized.

Definitive Diagnosis and Treatment

The child's receiving adequate psychiatric care is based on a complete and useful diagnostic and prognostic evaluation. The timing of this step will vary with individual circumstances. Sometimes the clinician will first see the child in an emergency and have to respond to his presenting behavior and its immediate consequences. At other times, he will be furnished some descriptive data about the child and asked if they indicate a possible psychiatric problem. In either event, the psychiatrist will eventually have to recommend not only whether and when a further workup should be done but also what his own part in it should be. The choice of alternatives may be: following the child's course at secondhand for a while; doing the whole evaluation himself; enlisting other professionals to examine the child while he studies the parents and community; or referral of the whole case to a specialist colleague or clinic. Relationship to the original referral source, personal expertise, and availability of other resources will all be factors in the decision.

The diagnostic process is considered in detail in Volume 2, Chapter 1. It aims at a formulation of the child's status in terms of his endowment, the genetic and dynamic elements in his illness, his overall healthy and maladaptive potentials, and the assets and weaknesses in the family and the larger environment. It should culminate in a clear treatment plan which takes into account the child's "treatability" under different conditions.

Such answers cannot necessarily be expressed in terms from a nosology based on symptoms or one of reaction types. Symptoms in the child will generally be nonspecific and phase-related whatever the etiology of his problem, while any disturbance involving predominantly psychological components is a reaction type (Group for the Advancement of Psychiatry, 1966). Therefore, the conceptual steps in diagnosis would be to identify the determinants of symptomatic behavior, to spell out the goals of change in the child's existence, and to select the intervention methods to achieve them. The following categories can provide some guidelines for such an approach.

1. *Reactions to current crises* or external events include situations which are largely responses to important happenings in the child's milieu, to expectable growth processes within him or, in early stages, to frustrations or blocks to continued development as a result of inappropriate handling and stimulation (Freud, 1952). In this category, the child might have distortions to solutions in developmental stages, or in habit or adjustment patterns, such as expectations from relationships or the environment. Initial goals would include environmental modification and provision of new opportunities for the child to use his abilities to master his situation. Tactics might be brief support through parents, temporary help across adjustment hurdles with peers or in school, or changes in family activity patterns.

2. *Surface conflicts* entail disordered functioning as a manifestation of a

clash, primarily at the conscious level, between the child's drives and feelings and his environment. These might be around academic demands, social pressures, sexual impulses, or the advent of siblings. There would be a greater contribution from the child's side in terms of the particular meanings to him of events about him; the nature of his adaptive resources would also have played into the problem's arising. A greater degree of intervention would be required to achieve goals involving the environment, the child's ways of responding, or both. Changes in intrafamilial functioning might be sought through family or couple therapy, in peer-group interaction through structured experiences or the support of additional figures for identification, in school by class reassignment or organized tutoring, and in the child through counseling or focused psychotherapy.

About 80 percent of children's mental-health problems fall into the two groups above and often respond to surface approaches. These conditions are not static and may go on to have a longer-term distorting effect on personality.

3. The group of *internalized conflicts,* into which the others may evolve, covers a broad range of stable maladaptation's, resulting from and perpetuated by largely unconscious intrapsychic conflicts, whether inter- or intra-structural. While the environment continues to influence functioning and is important in recovery, effective treatment for this group of children

has to include the psychotherapeutic opportunity to deal with conflicts on the level where they are occurring. Ancillary to this may be measures to help correct deficiencies secondary to the internalized problem or to channel developmental forces freed up during treatment, e.g., remedial education, a therapeutic milieu, or treatment for parents.

Implicit in the approach so far is the recognition that psychotherapy is not the only good treatment and that manipulation of the child's environment is not necessarily fruitless. Individualized planning goes on to take into account the question of "treatability" (Group for the Advancement of Psychiatry, 1973) The answers should be free of distortions due to the diagnostic team's personal backgrounds, experience, therapeutic optimism, or sociocultural stereotypes. Valid ones will be built up from knowledge of the child's characteristics and potential, family variables and the community setting. Children's therapeutic potential cannot be inferred from diagnosis. It differs according to their capacity for conceptualization and communication, psychological mindedness, object relationships, frustration tolerance, and the degree of secondary gain of their illness. The family's likely participation in treatment will reflect their cooperation, solidarity, emotional health, general outlook on life, ties with the community, and dependence on the child's illness for maintenance of its own homeostasis. Inputs utilizing the extended family and its resources may be important even in this modern society. The value of community facilities and supports will depend not only on their existence but

availability.

The plan will specify whether psychotherapy is needed and how it fits in with other efforts to help the child resolve his problems and to potentiate his healthy development. The most appropriate setting for this total program will be identified: (1) Treatment as an outpatient while living at home is best if it is workable. This will depend in general on the child's motivation and ability to cope during treatment, as well as the family's adequacy in meeting his needs and their willingness for him to be treated. Removal from the home may be necessary because of the stresses the family brings to bear on the child. Sending the child elsewhere only because outpatient resources are not available is highly regrettable but may sometimes be the least of the evils.

Specialized day-care facilities are a useful alternative for children needing a more controlled environment than the home setting can provide, especially if they also require ameliorative educational, occupational, recreational, and/or group experiences. (3) Out-of-home placement, as in residential treatment centers or foster care, is essential in some cases. Children may have to be separated from a pathological family situation to give psychotherapy a chance to operate. Others may be unable to tolerate the closeness of or distortions in interactions in a family unit and will engage in severe provocation or acting out. More familiar are those who act out and need the limits and behavioral controls which only a specialized milieu can

provide.

The diagnosticians' efforts and the family's investment in the process become meaningful only when the results of the work are interpreted in a useful way. At this point, the parents (and often the older child) are entitled to have presented to them a dynamic formulation, diagnosis, and treatment plan. The ultimate aim is to establish a common understanding and purpose among all concerned. This step is as technically difficult as it is important. Care is in order to avoid factual misunderstanding, to recognize resistances, and to assure that the consensus reached is based on what is really right for the child rather than on political or expedient compromises.

The general psychiatrist's role vis-a-vis the child's further treatment should be decided according to individual needs rather than any set model. The comments below apply to possible participation other than as the child's therapist, i.e., in some role involving work with the parents as an aspect of treatment of the child. Philosophy and format of this approach have changed over the years. Throughout, however, it has been a basic tenet that parents' participation is important to the success of any treatment plan for the child.

Indirect treatment of children through their parents has a long and honorable history. Some years ago the assumption became prevalent that children's disturbances originated in those of their parents, who were

therefore made the principal therapeutic targets. Children are nowadays understood to make unique contributions to their problems and parents have become partners in the therapeutic effort. It may nevertheless be decided that the child not be seen himself, but be treated indirectly, either throughout or in the opening stages.

When a child is to be seen directly, many psychiatrists and clinics follow a *collaborative model.* In this approach parents see someone else and it is understood that information will be exchanged between the therapists. Sometimes there are indications to avoid such a split, though not to do family therapy, so both child and parents have separate sessions with the same person. The general psychiatrist may have been treating one or both parents before the child himself came to diagnostic attention. Changing the therapeutic contract to one of collaboration with the child's therapy will usually be contraindicated.

Age of the patient and nature of the treatment are important factors. In the case of a younger child in psychotherapy, parents may have to go beyond making his sessions possible to being the carriers and implementers of critical environmental factors. Their involvement will therefore have to be greater. Parents may be seen less frequently if the patient is an adolescent, depending on the degree of his independent functioning and the need to have the treatment be his own. The relative importance of advice-giving, ego-

supportive techniques, focusing on the marital relationships, or the depth of inquiry into parents' personality functioning differ from therapeutic approaches not oriented to a child.

Whatever format is found to be best adapted to the individual situation, some problems are typically encountered as parents go through treatment with their children. At the outset, parents will often feel to blame for their child's difficulties, intellectual knowledge and reassurance to the contrary notwithstanding. Having to bring their child to someone else for help can be a blow to their selfesteem, especially when the help is perceived as personal or competitive with parents rather than truly professional or scientific. Such feelings are often reflected in questions about what the psychiatrist does with the child or how he helps him. Rivalrous impulses may be stimulated, and be similarly expressed. When such questions come up in their own sessions, they can be put into context and used to advantage. However, parents may act out their feelings by quizzing the child about what went on, coaching him in what to say, or even joining him in the treatment room. Such behaviors will increase the child's concerns about confidentiality, precipitate further conflicts of loyalty, or even convince him that the therapist is the parents' agent.

Narcissistic issues also enter into initial treatment planning and arrangements. From the child's side, it should be recognized that a

therapeutic alliance may begin to form during the diagnostic sequence. If the psychiatrist ends up working with the parents, feelings of loss or rejection can be carried over into the child's first contacts with his own therapist. Parents already in treatment may ask for and get a referral for a child who is arousing warranted concern. They may then experience it as disapproval of themselves or preference for the child. Psychiatrists are familiar with the phenomenon of children being brought as tickets of admission by parents who really want help for themselves. From the opposite end, others will find the child's needing treatment a means of getting out of their own. This is even more likely when the person dealing with them around the child can be seen as more tolerant, giving of advice or approving of self-sacrifice for the child's sake.

During treatment parents may feel disadvantaged versus the child, who comes and plays during his sessions, while they confront painful issues in their own counseling or therapy. Guilt may prevent them from spontaneously ventilating their resentment of the inequality or cause them to deny their real difficulties with treatment arrangements until it is too late to relieve them. A parent's neurotic need to fail may show up in their work here as elsewhere.

As the child gets further into the psychotherapeutic process, his regressive shifts may discourage or infuriate those around him. Parents also need help in the face of the aggressive and erotic energies which are freed but

not yet directed appropriately. Particularly stressful is a child's questioning of family norms and adults' self-destructive behaviors, or his insistence that they be consistent, often with threats to report them to the therapist. The child's new behaviors in this area touch upon the chance of his upsetting the family homeostasis by getting better, and alertness to this danger can help to meet it in time and work it through before it leads to premature termination.

The Impact of Family Illness

Children are inevitably influenced by what goes on with other family members, whether these are healthy or have a medical problem. The psychiatric nature of a relative's illness or its severity do not automatically augur more damaging consequences. Its impact will be determined by the vectors pertinent to the meeting of the child's basic needs, his opportunities for growth, and the intrapsychic events that result. Somatic diseases, neuroses, and personality disorders in those around him may lead to more profound dysfunction in a child than psychoses or severe depressions in the family. It is more likely, however, that concern about children is generated when their parents fall into the latter group. The following discussion therefore centers on such cases of illness in the family. Some reference will be made to other situations, including normal ones, by way of illustrating the considerations which apply.

When his seriously ill patient is a parent, the psychiatrist faces the complicated task of deciding which (if any) steps are in order to minimize adverse effects upon children. A number of perspectives can be employed: (1) the child will participate in changes or distortions of general family functioning resulting from a member being or becoming ill; (2) direct effects upon the child will depend on his specific relationship with the ill member and what both bring to it; (3) interventions to aid the individual child should not only meet his needs but those of the whole family from which he will then profit indirectly.

General Family Response

A family's way of coping with the stress of a member's illness depends on its existing strengths in organization, integration, social affiliation, interpersonal ties, and material resources. While the member is unable to function, such variables influence the degree of overall family disorganization, deprivation of other individuals, anxiety, and acting out. They underlie the way the family returns to previous patterns as the member recovers, or the way it makes a long-term adaptation if the disability is chronic. Some shifts are probably inescapable in the areas of status and role evaluations (especially dominance[Anthony, 1970]), the direction and intensity of interpersonal transactions, affection, discipline, and daily operations. Social isolation may result from preoccupation with the member's illness and the

family's difficulties. In fact, the absence of at least some reorientation of interest and concern might raise questions about earlier family relationships and/or their current adaptive efforts and intrapsychic defenses.

The child's experience depends upon: his age, sex, and ordinal position, his role allocation within the family, and his habitual style of functioning within its socioeconomic and cultural context. The range of possibilities is almost infinite and includes those in which illness (as also in cases of actual absence) of a parent or sibling results in the family's being better off. An urban, two-parent model can be used to illustrate the effects of incapacity of different family members assuming that no one else fills in for them. It is recognized that none of the roles is fixed or exclusive in real families, especially with regard to the meeting of emotional needs and, increasingly, activity outside the home.

Illness of the *father* would thus theoretically be expected to mean the endangering or loss of the source of material support and status, the deprivation of a key model for extra-family socialization, and a threat to an object of libidinal and aggressive drives involved in the processes of identification and superego formation. The child, as a result, would experience increased adaptive and social problems outside the home, sacrifice of maternal care and attention to the father with increased wishes and/or competition for it, and added obstacles to the resolution of

psychosexual conflicts.

Serious illness in the *mother* would usually be more disruptive, as it would lead to withdrawal of the often predominant source of emotional security, dependency gratification, and maintenance of intrafamilial homeostasis. In addition to the loss of the specific functions the mother may have served in supporting social interaction and appropriate identification, the child would experience ubiquitous emotional deprivation which other family members would not be in a position to make up, leading to consequences at all psychosexual levels.

Illness of a *sibling* might mean massive diversion of parental attention, the re-arousal and accentuation of dependency strivings, regression and interference with the resolution of conflicts involving the parental figures. Even without this, there would be loss of a co-participant in the mastery of tension on the way toward social maturity and functional autonomy.

Thus general family disruption, secondary to a member's serious illness, can be translated into the essential functions and inputs of which the child would be deprived. The ultimate impact upon the child would thus be a function of the duration and degree of the deprivation. This, in turn, would depend on the outcome of the individual's illness, on the pace and effectiveness of the whole family's coping efforts and, most critically, on the

moving in by others to meet the various needs of the child. These do not necessarily operate in the same direction, though a better prognosis for the patient will certainly ease the load upon the rest of the family. Nevertheless, physical attention, training in self-care, stimulation, maintenance of household routines, and encouragement socially and academically may go by the board or be filled in for the child irrespective of a parent's psychiatric course.

Seen as a whole, the response of some families is marked by growth of collective effectiveness and healthy development of the children. Here, the clinician may find it advisable to defer recommending shifts in their living situation. Some indices for making such an estimate are drawn from or comparable to those used in prognosis of an individual patient's recovery from a severe illness. From the side of the healthy parent(s), these could include: a history of satisfactory childhood; good marital relationships; stable and mature friendships; successful school and work performance; demonstrated ability to cope with previous life challenges and everyday problems. Comparable criteria for the children in such a holistic approach to the family would be: evidence of timely and successful meeting of developmental challenges (achieving a sense of basic security, autonomy, initiative, industriousness, etc.[Caplan, 1964]); degree of resistance to pathological regression in the face of the current stress; sustained satisfactory school work and peer relationships; ability to openly and willingly collaborate

with other family members to keep the home running. Another favorable sign would be the observation that the child is able to tolerate his ambivalence towards the ill family member, especially a parent. This might be seen in a child's recognition of the fact of the illness and of its arousing feelings within him, accompanied by an approach of tolerance and love, rather than one of denial with consistent rage or withdrawal.

The overall picture in other families will not be consistent with a favorable expectation. Application of the indices noted above may give a negative answer for some or all members. There may be frank psychopathology, a tendency towards disintegration of mutual activities, marked constriction of interests with excessive anxiety about security and/or progressive alienation of individuals from each other. With their greater dependence on other people and on the structure of the family unit, children in such situations could be expected to suffer more intensely from its breakdown.

Separations and Losses

Even if it remains together in the long run, the family with intrinsic weaknesses may also be more prone to transient breakups. Experiences of separation and loss can be a repetitive theme in the lives of children with severely ill parents. Moves in and out of hospitals are more frequent now that

maintenance in the community is easier and has become official policy. Community rejection, due to disturbed behavior or fearful stereotypes, can cause frequent changes of address. Parental discord and violence, material insecurity and broken marriages, often secondary effects themselves, add to concerns about separation. The clinician would then have to consider the relative merits of the children continuing to remain within the family life-pattern, allowing for the possible effects of ameliorative maneuvers, against the long-term risks of chronic exposure to such events. He may also be in a better position to provide helpful intervention for children when such traumata have occurred but are still fresh and reversible.

The understanding of the nature and effects of separations raises questions of definition. Do children mourn and how is this related to adult mourning of a permanently lost object? Is attachment a form of instinctive behavior or associated with gratification of other instinctual drives? What are the roles of both parents? These questions are being actively worked on. For present purposes, we shall suffice with describing the sequence of observable reactions of a young child to the loss of an important *(the* important may be more apt) figure. Following Bowlby (1973), four phases can be described: (1) *numbness,* lasting a few hours to a week, perhaps interrupted by outbursts of intense distress and/or anger; (2) *protest,* with yearning and searching for the lost figure, lasting months to years; and (3) greater or less degree of *detachment* from the old object; and, (4) hopefully, *reorganization.*

Such a sequence may have a profound effect on the child's affective life and ability to form relationships. It is accompanied by intense and disturbing fears of abandonment, yearning for the lost object, and anger at his absence. The urge for the lost figure may lead to direct action or take the form of withdrawal into fantasy. Some adolescents, even many years after a loss, embark on a search for their origins reflecting the continued pressure of this urge (Blos, 1962). The child angrily reproaches anyone who seems to be responsible for his loss or standing in the way of reunion. The major part of his psychic energy can become bound up in these repetitive activities and thus impede his growth. One such experience, let alone repeated ones, may compromise a child's ability to feel secure with and trust other people, with far-reaching consequences for superego development, learning or identity formation, or the major task of the stage he is at.

The intensity and duration of reactions to separation should serve to highlight the importance of intervention to help the child through them with minimal long-term personality damage. To do this, application may be made of the psychotherapeutic principle that facing reality and being freed from the struggle with the past require appropriate understanding, support, and opportunities for expression of feelings about the lost person. This may be especially critical if the rest of the family are attempting to deal with their loss and ambivalence through denial, displacement, or avoidance.

Direct Effects of the Parent-Child Relationship

Examination of this area is of necessity a highly individualized matter. Children usually show different responses to parental illness, even when it is florid. This is to be expected from their being of different ages and at different points in their cognitive growth and progress along the developmental line from the mother-child dyad through the family unit into the outside world. Effects also depend on the extent to which they become enmeshed in the parental psychopathology.

Determinants of direct effects upon children can come from the following areas:

Constitutional Differences

As with other life experiences, a child's interactions with members of his family will be influenced by his unique endowment. Children with perceptual difficulties, physical handicaps or intellectual limitations will be readily thought of as more vulnerable to failures or disruptions in progressive growth. Under the best conditions of care, they can be expected to encounter problems around relationship, body-image, socialization and eventual independent functioning (Freud, 1952).

Even in the absence of marked disability, premonitory evidence of

vulnerability may be gathered from examination of the child's "temperamental qualities" (Thomas, 1968) These variables in individual endowment affect the functioning of children in any environment. Here we shall cite some possible implications of this general fact in families with an ill parent, to show that what is important to the child in the relationship is the kind of response, not the diagnosis.

1. *Activity level.* As a result of his normal high level (i.e., not the hyperactivity associated with neurological abnormality or psychopathology) a child may move about so rapidly and energetically as to repeatedly damage himself or household objects. Such a child may pose a threat to a parent who is struggling with his own aggressive impulses, slowed down by depression or psychotropic drugs, busy ministering to another family member who is ill, overburdened by having to do the jobs of both parents or especially irritable during withdrawal. The feedback to this child may well have as its major theme his "badness" and include demands for self-restraint which he cannot meet. After a while, he may become depressed—if previous experience has laid the groundwork—or habitually disobedient—-if he gives up on trying to please. On the opposite end of the spectrum, a very slow-moving child may be unable to mobilize himself fast enough to benefit from the few opportunities for pleasurable interaction or outside stimulation which an intermittently available parent can offer.

2. *Rhythmicity.* Individual differences in this area may prove an obstacle to anxiety-free functioning during a parent's illness. One child's diurnal cycles (hunger-feeding, sleeping-waking, elimination) may be so regular that "you could set your watch by him," while another's may be highly erratic and unpredictable. The former may experience as highly disruptive and anxiety-provoking the shifts and adjustments which the family must make to cope with illness. On the other hand, a parent whose illness or recovery process makes her very needful of structure and regularity herself may find the second kind of child beyond her ability to respond to, leaving him either uncared for, the object of frustrated attack or a believer in the basic inadequacy of his bodily processes.

3. *Adaptability.* Children who can change a previous behavior pattern to one which works in a new situation only after repeated, consistent exposure with a maximum of anxiety may be unable to adapt to the changes in behavior of an ill parent, even when these in themselves are not extreme. Rather than making the necessary shifts, they may withdraw and thus deprive themselves of the benefit of the parent's being in fact available to them on an at least minimally adequate level.

4. *Other temperamental qualities,* such as the ability to react to the environment, perseverance at tasks in the face of distractions and frustrations or typical mood, could be similarly discussed. It is difficult except

in introspective research with quite young subjects to pick out one or another discrete "quality" in pure culture. Application of the constitutional point of view can be made, however, in history taking. Practically, it is most likely to be called for in the case of children whose behavioral style demonstrates the effects of typical constellations ("clusters") of traits. Their clinical picture will of course also show the blurring of temperamental characteristics by the kind of responses the environment has previously made.

a. The most obvious group about whom there may be concern on this basis are those who are "difficult" to raise because of their irregular biological functions, predominantly negative responses to new stimuli, slow adaptability, intense reactivity, and frequently negative moods. Such children present any parent with special challenges for consistent and tolerant handling based on an objective recognition of their patterns of reaction. If such essentially unusual parenting is forthcoming, these children can master in a stepwise manner the requirements of socialization. With parenting that is "good enough" for most children, however, this group face greater odds of developing behavior problems and engender in their parents feelings of resentment, guilt or helplessness. Their difficulties would be compounded if the parenting available to them was by someone already beset by her own problems in being consistent, tolerant, and objective while struggling with the internal issues raised by her own psychopathology.

b. The child who is "slow to warm up" because of slow adaptability and initial negative responses to new situations may withdraw in the face of situations where getting his needs met requires rapid and effective moving in. With fortunate parental and school handling, such a child can become interested and involved. A mother who is apathetic, especially needy of approving feedback, or driven to succeed may neglect a child without the sending power to engage her interest or contribute to his withdrawing by actively turning him off. Similarly, having a teacher who is unable to meet him where he is may deprive him of potential opportunities for satisfying achievement and introduction into a supportive peer group, with further adverse consequences for his sense of security and self-esteem.

c. Surprisingly, even the "easy" child whose positive moods and approach, regularity and easy adaptability endow him with the ability to evoke approval from others may become a casualty of his own strengths. Such a child may accommodate easily to the idiosyncratic qualities of an ill parent and to deviations from conventional roles and procedures which the family made in order to be able to function together. Having adapted well to the ground rules at home, he may be thrown into conflict when introduced into a school or peer group setting with differing ones. He may thus find himself confused, overwhelmed, inept, criticized, punished, or ridiculed. Through efforts to defend against this new stress, such as withdrawal, avoidance, counterattack, or overcompensation, he may come to present problems in the

form of aggressive outbursts, academic underachievement, "bossiness," or nonparticipation.

In this last case, we are not referring to children whose problems stem from deep-seated personality distortions they have suffered in adapting to parental illness and family change. They result rather from the conflict between these home expectations and those of the world outside, becoming manifest at times when they try to make the shift.

Age

In general the younger the child, the more vulnerable he will be to both the acute and long-term effects of growing up in relationship to a disturbed parent (Chandler, 1968).

1. *Infancy.* Spitz's (1965) classification of psychogenic diseases in infancy illustrates the possible damaging effects of "psychotoxic" maternal behavior patterns. Thus, "primary overt rejection" of the "passive" type may be associated with coma in the newborn (infants with mothers who globally reject them in an active manner, if they live, usually are not kept by them and thus cannot be studied in this way). "Primary anxious over-permissiveness" has in many cases been associated with three-month colic; "hostility in the guise of anxiety" has been a factor in some infantile eczemas; "oscillation between pampering and hostility" is implicated in hypermotility (rocking);

"cyclical mood swings" with fecal play; "hostility consciously compensated" with aggressive hyperactivity. Various combinations of tendencies to somatization, pathology of object relationships, depressive constellations, and personality disorders may follow later in life.

If there is quantitative (as opposed to the "qualitative" types above) inadequacy of care, the infant is at risk of experiencing varying degrees of home-based maternal deprivation. Children cared for by psychotic mothers on their own, especially if there is associated depression, may be somber in mood, irritable, unspontaneous, hypoactive and retarded in motor activities. Early adverse effects may be growth retardation, nutritional deficiency, disorder of basic biological functions, pica and habit disturbances, to name a few. The correlation of maternal deprivation with later psychopathology, especially delinquency, is by now widely recognized (Eisenberg, 1958).

2. *Later stages.* The parent's diminished functional capacity due to illness and the re-arousal of his own conflicts may also handicap him in meeting the phase-specific challenges posed by the child's later development (Anthony, 1970). These are outlined briefly below and mentioned in more detail elsewhere in this chapter and in others in this *Handbook.*

a. Separation-individuation. Giving up the "symbiotic" child; relating to him on a new level; supporting his nascent autonomy and new abilities.

b. Struggles over mastery and control of bodily functions; sadism; libidinal-aggressive balances.

c. Sexual interests and seductiveness; family roles.

d. Acceptance by the community; new identifications; sharing the child; moral and ethical standards; intellectual abilities.

e. Adolescent sexuality; new forms of aggression; adolescent "upset"; changing loyalties.

Differences in Involvement of the Child by Another's Psychopathology

The effects upon children of overt, severe mental illness in the family have as yet not been systematically explored. Available information does at least point up the dangers of making facile assumptions in this area (Rutter, 1966).

1. The incidence of neurotic disorders is not higher in the children of psychotic than of nonpsychotic adults. However, conduct disorders are more frequent, with differential effects according to sex. Boys are more susceptible to developing antisocial disorders. Child-rearing philosophy and methods of discipline have less bearing on such an outcome than family stability and the quality of relationships.

Precise work in this field is made difficult by its dependence on how study populations become available. This, in turn, is influenced by social attitudes towards the definition of delinquency in boys and girls and the two sexes' different means of expression—aggression versus sexual acting out and pregnancy.

2. Further uncertainty is introduced by the discontinuity between the clinical manifestations of emotional disturbance in the same individual in early and later life. The possibility of a worse long-term prognosis for some of these children is raised by follow-up studies which show a high incidence of teenage or early adult schizophrenia after an earlier antisocial picture.

3. When clear psychopathology does become evident in the offspring of psychotic people, neither its form nor its severity correlates with that of the parents. Such a similarity is probably more common in the ill children of adults with neurotic or affective disorders.

4. A woman's psychosis does not automatically render her incapable of mothering adequately. Her ability to do so seems more related to her general capacity to relate to others.

5. There is more danger to a child if he is directly involved in the parent's current illness:

a. He may be a figure in the delusional system; an object in the depressive constellation; a target of intense hostility and ambivalence by virtue of sex, ordinal position, parentage or physical characteristics, and resemblances; the "cause" of a family or personal misfortune which precipitated the other member's falling ill.

b. A psychotic mother might maintain a state of emotional symbiosis with her child far beyond the time of his normal psychophysiological need for such a relationship. Thereby, he will tend to identify only with her and be isolated from peers and other adults. Among the possible additional sequelae can be crippling dependency, interference with cognitive development, sharing the maternal delusional beliefs and/or frank folie a deux.

c. Imitative sharing of someone else's defense mechanisms can leave a child poorly equipped to handle the pressures of his own life. Comparable processes may be involved in the frequently cited "contagion" of neurotic traits in a family.

6. Even when direct interactions are benign for the child, illness may have a meaning for him in reference to his own drives, leading to a sense of responsibility and feelings of anxiety and guilt. This can occur independent of the actions or suggestions of others. It can be stimulated by the "healthy" parent turning excessively to the child for emotional and physical support or

making him a confidante in place of the ill spouse (Clausen, 1955).

7. While not specific to the family with known psychiatric disturbance, child abuse may be more likely in one whose members are already under stress, having problems with impulse control and susceptible to rapid displacements of blame.

Intervention

Looking out for children in the family adds another complex dimension to the already difficult task of delivering optimum care to the individual parent. While incomplete, the range of information available can aid in identifying more clearly the elements which can be helpful as well as hazardous to a patient's offspring or siblings. The conclusion that can be most confidently drawn at this time is that the key factor will be whether relationship experiences are consistent and developmentally appropriate.

Using this criterion, evaluations can be made of the impact of interpersonal contacts, the family's coping style, the community pattern of care and supportive services as well as of the direct parent-child relationship. Choice and timing of interventions for the sake of the child on a number of possible levels will be a matter of clinical judgment. We would suggest the overriding importance of helping efforts being coordinated and synergistic.

Treatment of individual patients should thus be oriented toward providing continuity of care, maintaining regard for the family's emotional needs and preventing its disruption by social and economic by-products of the one member's psychological decompensation (Pavenstedt, 1971).

In large mental-health programs, these goals should not be obscured as patients go back and forth from hospital to outpatient status. Different social agencies move in and out of contact with the family to deal with concrete reality problems. Efforts to assure adequate regard for the psychic realities may be especially valuable at such times. Homemaker services should be geared to furnishing consistent maternal surrogates who have been educated to provide the kind and intensity of relationships children need.

The scope of psychotherapeutic efforts might be usefully extended to supportive work with the healthy parent or the family group. Children may need to be seen individually, particularly during unusual changes in parental functioning and at times of separation. The psychiatrist can sometimes be more effective by serving as consultant and preceptor to people with an existing natural connection with the family, such as empathic relatives, ministers, pediatricians, school counselors, or visiting nurses. He should be responsible for integrating information fed back to him into an evolving picture of the nature of the child's progress.

If this picture turns out to be one of continued regression or developmental arrest despite the multiple channels through which help is being offered, the question of environmental change has to be answered. Brief placements with appropriate relatives, a specially trained foster family or even a children's shelter may give all concerned a breather and allow better functioning after reunion. By and large, such measures often prove less helpful than hoped for because of the chronicity of the family dysfunctioning and the effects of the separations in themselves. Should the prospects be that placement will have to be long-term, it is highly desirable to plan it so as to obviate interim shifts. The setting chosen should be able to provide the child with emotional experiences which will make up the deficiencies he has suffered in the past. A good residential treatment center may be necessary if the children themselves show significant internalized psychopathology. If they do not, it should not be assumed that such a specially oriented and expensive milieu will be the best one for them. Special foster homes with built-in ongoing parent education, counseling, and psychotherapy for the child have demonstrated their value in this regard (Fine, 1966). Boarding schools, though academically and physically adequate, often emphasize peer relations and social skills at a level beyond that of the child's basic needs.

Consultation and Collaboration

Children are often involved at second hand in the general psychiatrist's

other diagnostic, therapeutic, or consultative activities. The extent to which children's interests can be taken into account depends on the nature of the work.

At times, there are technical contraindications in the psychotherapy of an adult to raising or responding to questions about the impact on the patient's children of contemplated life decisions such as initiating a pregnancy, having an abortion, making a move, or separations. Factual information for the patient may then have to come from other sources or be provided by arranging a consultation. How these facts are perceived and dealt with can, of course, be used in psychotherapy as can any other material. For example, they may illuminate unconscious processes originating in the adult's own childhood. In the treatment of parents, the psychotherapist's sensitivity to what his patient is experiencing may be heightened by a knowledge of the phase-specific instinctual pressures, superego conflicts, and problems in socialization which children face and carry over into what they do with and to their parents.

At other times, such as in work with social agencies, the psychiatrist may be asked to evaluate adults as part of decisions specifically related to children's welfare, e.g., placement in adoption or foster care, child custody, or employment. Other professionals usually have screened such adults and refer only those about whom there is concern. The psychiatric evaluation would

rely in the customary way on examination of the individual's life history, current adaptation, and whatever can be anticipated from these for future functioning. Here, additional useful dimensions may be drawn from knowledge of the expectable problems in children's development and how they would be reacted to.

Adoption and Foster Care

Adoptive and foster parents share many motivations with those who become (and remain) biological parents. Among these common motivations may be forces aiming at compensation or restitution for their own early life experiences. Such variables could include abandonment, other separations, parents who devoted themselves to others, unusual roles vis-a-vis siblings, positions of esteem in the family, distorting conflicts about discipline or sexuality, frustration of vocational goals, frank psychopathology, etc. Other influences can be traced to events during adult life and in the marriage. A couple may want children to complete the family picture, to solve problems they are having individually or between them, or as an alternative to a currently ungratifying work or social life. The problems these couples have do not differ in number or severity from those of people raising their own offspring. On the other hand, there are psychological features of special importance for non-biological parents. These, and the fact that their becoming parents entails successive decisions on their part and by social agencies, offer

some unique opportunities for preventive psychiatry.

The emphasis here is on factors potentially conducive to maladaptive responses. Those evident in advance of placement should by no means be seen as a priori disqualifying, but rather should be taken into account prognostically. Ideally and ethically, they will be shared in a tactful and professional manner with consultees. In fortunate cases this will help the prospective adoptive or foster parents to clarify their motivations and make the best decision for all concerned. An awareness of such factors may assist in dealing with problems brought to psychiatric attention in the years following placement.

When a couple have become prospective adopters due to infertility, they will have been confronted by the need for major intrapsychic changes involving self-concept and body-image not infrequently built up in early childhood identifications and fantasies (Schechter, 1967). They miss the months of pregnancy which serve to initiate attitudinal, attachment, and role shifts in biological parents (Benedek, 1959). A comparable period may be provided by the usually lengthy preadoption screening and waiting for the baby, if this is not excessive. Questions about successful outcome can be raised during this period by faltering of initial motivation or the decrease of the desire for a child. Taking in someone else's child can be a powerful stimulant to rescue fantasies. Rage at disappointment of these fantasies may

be overt; defenses against the rage may lead to inconsistent limit setting. Receiving the baby immediately after birth provides the best opportunity for the mother to engage with it in the emotional symbiosis which is the foundation of close relationships. The father's sharing in this effects the assimilation of the child into the family unity. If the adoption was for the sake of one parent, the way is open for interferences with this process. Some parents may be unable to allow separation-individuation out of fear of losing the child to others. When aggressive and sexual drives become manifest they may be ascribed to the "bad" biological parents, especially if conception was out of wedlock. Social encounters over the years may lead to a need for help with the parent's or child's sense of being different. The defense of denial such experiences can mobilize may set a pattern for handling other family stresses and conflicts, including the fact of adoption itself. In contrast, some parents respond to the continuing narcissistic pain of barrenness and "defectiveness," which may be projected onto the child as well, with a persistent proclaiming of adoptive status. The not uncommon birth of a "natural" child following an adoption may set into motion mechanisms of scapegoating, rejection, or overcompensation of the adopted child which show up in his behavior. Parents may not experience successive reactivation of the earlier periods in their own lives as the child passes through the stages of psychosexual development and continue to relate to him on inappropriate earlier levels. Persistent infantilization may also be resorted to in the service

of the wish to stave off adolescence. This period may be exceptionally threatening on a number of counts. Parents may envy the child's (especially the girl's) ability to conceive, at the same time fearing that (s)he will imitate the biological parents by doing so. The weaker incest taboo may bring normal sexual rivalries closer to the surface and repression may fail altogether. A basic threat to parents during adolescence is the chance of the child's putting into action his wishes to find the biological parents. If the child is adopted later, especially after age two, the images of previous parents or surrogates he is carrying around and reacting to intrapsychically may cause him to feel and act like a stranger in his new home.

These same issues affect foster families. Here, however, reality factors create important additional complications (Taylor, 1967). Couples may become foster parents once, or as a career. The mother is generally the dominant figure in recruitment of homes, consideration of children, and dealings with the legally responsible parties. There are usually continuing financial transactions around the children's care. Entry into foster care is on an essentially pragmatic basis. The children are a highly diverse group in age, history, and functional capacity. Many show the signs of neglect, abuse, or family deterioration which led to their separation from their biological parents or relatives. There will often have been other intervening moves or periods of institutionalization in their lives, with the added effects thereof. Placement may be designated as emergency or temporary. Even when it is

planned to be permanent, chronic themes of uncertainty and tentativeness may pervade the relationship. These may derive from the constant presence of the monitoring outside agency and/or legal requirements for periodic review and court appearances. The latter, often intended to assure the children's welfare and preserve biological parents' rights, can repetitively stimulate anxious fantasies and clashes of loyalties.

The foster role is socially more painful than the adoptive for both children and parent. Change to the more comfortable relationship may he resisted within the foster family because of the long-term emotional commitment involved. More often it is obviated by the natural parents' wishes and fluctuating status. The children, or what they represent, are important to them. They are not easily given up for adoption even in the face of reality. The natural parents may engage the children in their maneuvers to deal with their own ambivalence, deny loss, and protect their self-concepts. Their intermittent appearances and mixed messages are probably the most potent harriers to the children's being able to work through their own mourning, resolve relationship conflicts, and become able to respond to new opportunities for psychosocial progress.

Such problems have led to serious doubts about the effectiveness of foster care and to calls for its abandonment in favor of professionally staffed residential facilities, especially for children already showing stigmata of

disturbed development (Wolins, 1964). Any population of children contains some who do need such settings. Often, however, foster families cope well. An understanding of their specific problems and the needs of a given foster child may he put to surprisingly good use. Data collected during the problem child's often checkered preplacement career can yield insights into his individual makeup, the likely kinds of adjustment difficulties and the frustrations and gratifications parents can expect from him.

Longitudinal observations of couples functioning as foster parents are often at hand to help in identifying their strengths and vulnerabilities. Some may be known to agency professionals as preferring and doing well with children up to age three and then losing interest. Others tolerate aggression well but sexuality poorly or vice versa. Adolescents are fun for some, intolerable for others. Intellectual standards or attitudes toward physical deformity may be highly significant. In certain homes children of any age do well, but each transfer out can be exceptionally painful to all, with depression for the parents and deterioration of behavior for the children. Opportunities thus exist for informed prediction and more precise matching of placements (Pratt, 1971). The phenomenon of foster parents "wearing out" as children grow older, even in the absence of obvious adolescent problems or stress, may direct efforts to make the children's progress toward independence a source of continuing satisfaction rather than the harbinger of eventual aloneness. The psychiatrist's awareness of unconscious meanings and

fantasies may contribute to management procedures which better reconcile parents' aims while establishing an emotional kinship with new children with the ongoing responsibilities of social agencies for them. Needs for focused educational or supportive measures may become evident in the light of knowledge about how children mourn and how their idealization of and intent search for old objects may threaten new ones who are offering themselves. In programs with built-in psychotherapeutic resources, such insights may specifically determine when, how, and with whom even the obviously disturbed child begins treatment.

Child Custody

Psychiatric status of family members at times enters importantly into court decisions in cases of family breakup and dispute over custody of the children. This consideration may become more common as legal philosophy and codes evolve in response to new knowledge and social change. The prevailing view has been that mother is indispensable until at least preadolescence. This meant that custody by her was presumed to be in the child's best interests unless proven otherwise, a process often fraught with severe psychic distress to all. There is now a movement toward more flexible definition of the child's "best interests," using meaningful criteria which include the mental health of the competing parents (Benedek, 1972). The psychiatrist's participation in this area can have high preventive and

educative value.

The actual assessments of family members might best he as part of a team including specialists in clinical psychology and child development. The work's purpose would be best served by orienting it toward the nature of the parent-child relationships rather than toward static nosologic labeling. The aim would be an understanding of the dynamic interplay between parental functioning and children's individual characteristics and needs, and the probable developmental consequences in the phases ahead. As described elsewhere, the fact that a specific diagnostic finding has or has not been made in a parent is in itself no guarantee of pathological or benign influence on his or her child. The consultant should communicate to the court the result of such an individualized evaluation in a way which demonstrates its rationale, teaches the relevance of the variables, and translates the observations into a conclusion which can be put to use judicially.

Much has been said about the effects of separation from mothers. A word might be in order here about the meaning of father absence, which has been of concern particularly around male children's development. Some approaches to this question have concentrated on sexual preferences in adult life. Employing permutations of masculine-feminine, active-passive, and present-absent factors yields a set of expected outcomes, such as varieties of homosexuality. Other studies have looked at the effects upon boys of father

absence in fantasy and behavioral traits during later childhood. The general impression is of increased passivity, feminine identification, and decreased masculine interests. Correlations of teenage delinquency with father absence have received repeated attention. Consequences have also been found in overall academic performance, discrete cognitive deficits, impulse control, and many other areas.

Some caveats should be kept in mind if one is considering application of these many theories and findings to clinical decisions and recommendations. From the research standpoint, the reliability of inferences from a study depends on its methodology and the level it addresses. There are differences in practical terms among: *sex-role orientation* (identification), which taps conscious/unconscious perceptions of male-femaleness; *sex-role preference,* reflecting preferential set toward culturally defined representations of sex-role; and *sex-role adoption,* which deals with observed social, sexual, and other behaviors. First of all, for many families father absence is in a sense normative. These include not only one-parent households but a number of occupational groups. Secondly, modern family life even in "intact" cases is increasingly matricentric due to home-job distances, female-dominated school systems, reliance on the mother-driven automobile, etc. Finally, the effects on personality development of father's presence or absence cannot be determined in isolation from other factors such as timing and length, the sociocultural milieu, surrogate models, maternal behavior and messages, let

alone the quality of his own mental functioning and relationship with the child.

An illustration from the authors' ongoing study of time-limited father absence in the military (Baker, 1968) may serve to point up the complexities in this field. Looking only at masculine identification, it seems that late oedipal-early latency boys proceed along this dimension while the father is away if the relationship with him has been good, the family keeps him idealized, involved in decision making, *and* the mother does not change her pre-separation coping style. His return is marked by interference with progressive identification probably due to rearoused rivalries. However, if mother becomes newly active and assertive during the separation, the boy's masculine identification can come to a halt though movement in the feminine direction does not replace it (Cove, 1969). Father's return is then attended by masculine identification starting up again if he rescues the boy from confusion about the sex-role meanings of the active-passive parameter.

Schools

The school is often the most consistent and sustained extra-familial social setting in a child's life. Especially in mobile or isolated families, other group and community experiences may be tentative or unavailable. School can be where the child has key successes or failures in emotional and social

growth. It thus has naturally attracted the interest of professions whose primary areas of concern are other than academic. In addition to their use in specialized psychoeducational facilities, there have been efforts to systematically integrate psychodynamic principles into general education. From time to time, nursery and elementary school programs have been oriented around psychoanalytic theory. Other workers have studied the psychological impacts of teaching styles, family-school interactions, the prediction of academic failure from emotional indices, cultural conflicts, and the value of counseling for academic staff.

Many of the general psychiatrist's basic tools can be used productively in consulting with individual schools or a local system. These include his developmental perspective, ability to tune in to the dynamics of institutional relationships and orientation towards providing children with a network of collaborative supports. The value of these skills is not contingent on a background of full training in clinical work with children. The general psychiatrist can also perform preliminary triage of cases of suspected emotional disturbance, with a back-up specialist for referral when indicated.

The consultant's approach to establishing a relationship with school personnel should respect their special knowledge and experience. The insights he contributes from his own field of expertise are intended to help them use theirs best, rather than as magical pedagogical solutions. It is useful

to begin with the working assumption that the school is able to solve most of the problems which its students present. It can also be expected that some children do, in fact, need outside professional attention. However, identifying and referring these individuals should be a step in an orderly, mutual process which begins with making the most of the potentials within the school itself.

The psychiatrist first coming into a school as a consultant is often met by requests to solve its long-standing problems with certain "hyperactive" or otherwise "unreachable" students. This group may contain a number of children who need full-scale diagnostic evaluations. As their problems are discussed, it may be possible to ask how they have responded to the educators' usual methods for providing learning and social stimulation. Such genuine requests for information by the consultant might in themselves serve to dispel teachers' unwarranted doubts about the validity of their observations and hesitations at making referrals. In other cases, looking at problems afresh can resolve blind spots about a child, clarify how to work with home-based interferences with his school adjustment and remind teachers of ways to reach him. If an outside workup is needed, its findings and recommendations might be "walked back" to the school (with appropriate attention to ethical safeguards). Recommendations can then be mutually and flexibly considered in the light of the resources available and a final academic decision made which resolves impasses on both the child's and the teacher's sides.

As trust evolves from working together around the most difficult cases, the consultant may be presented with less obviously dysfunctional children or asked about general issues in child development and school-home interaction. Such questions may come closer to the school staff's concerns about their own professional adequacy and personal reactions. Again, the consultant's focus should be on problems inherent in the work situation, not in the teacher or pupil personnel worker.

Success in being accepted more fully by a school carries with it the need to be more aware of potential hazards to the ongoing collaborative structure. The consultant is most effective if he continues to be careful to observe the system's ground rules, to work within its communication channels and to use customary professional tact. In time, he may be turned to for guidance about the kinds of teaching programs and relationships which would be most profitable to children of different ages, sexes, and socioeconomic backgrounds. Advice may even be sought about assignment of students to specific teachers the consultant has come to know. Such requests should be met with an eye to his appropriate professional identity and role. Oft-times flattering individual inquiries about direct psychotherapeutic help should be responded to on a similar basis.

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