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PRACTICE OBSERVED

Practice Research

Preventing psychological disorders in children of divorce: guidelines for the general practitioner*

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Preventing psychological disorders in children whose parents separate or divorce should be considered within the framework of current concepts and practices in general preventive psychiatry. During the past 15 years much thought and research have led to the formulation of the following conceptual model of prevention. The incidence of psychological disorder in a population is thought to be influenced by the interaction of four main variables, all of which may become a focus for systematic preventive programmes.

Framework

PRIOR RISK FACTORS

Prior risk factors are biopsychosocial hazards, consisting of isolated traumatic episodes or continuing burdens which have been shown by controlled empirical studies to be associated with an increased incidence of psychological disorder. These hazards include genetic defects, problems in pregnancy, birth trauma, prematurity, congenital anomalies, accidental injury, physical illness, hospitalisation, poverty and cultural deprivation, failure at school, family discord, family disruption owing to divorce or death, mental or physical illness of parents, and chronic illness of a sibling.

Combating such harmful factors in a community requires changing the ways of life of a population and the patterns of its health, educational, legal, and welfare services. These issues come within the jurisdiction of government, community, and professional authorities; family doctors can influence them only minimally by trying to increase the salience of the issue in the eyes of the policy makers through emphasising their specific implications for health.

Although these risk factors, especially in combination, will increase the likelihood that individuals who are exposed to them will eventually become sick, most of an exposed population will nevertheless remain healthy. During the past decade research studies have sought to identify the factors that protect an exposed population from becoming ill. The three variables discussed below are thought to be important. Preventive programmes have been developed in relation to each.[1]

COMPETENCE

Competence, a crucial variable, refers to an enduring quality of an individual's pattern of behaviour that is associated with his personal fortitude to master stress and privation in realistic and socially acceptable ways. Preventive programmes that focus on enhancing competence require educating people to master stress themselves and with the help of others and thus to develop expectations of personal mastery as well as an increasing repertoire of problem solving skills. Family doctors may make their contribution as part of their daily work with families of their child and adult patients if they use acute or chronic illness as an opportunity to educate family members in methods of healthy adaptation.

CRISIS EPISODES

Crisis episodes are periods of psychological disorganisation in individuals, lasting from about one to four weeks, when the person is in a life transition, such as moving home, changing school or job, getting married, becoming pregnant, or becoming a parent, or when the person is exposed to acute biopsychosocial hazards, such as becoming physically ill, having an accidental injury, losing a relative by death or desertion, or undergoing surgery. Such episodes are likely to confront many individuals with novel adaptive problems that are beyond their current capacity to cope. For a time they become emotionally upset, anxious, angry, and depressed, as well as disorganised in their thinking, until they work out ways of mastering their

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predicament or adjusting to it. They then return to a new steady state of psychological functioning.

The importance for prevention of these temporary transitional episodes of psychological disequilibrium is that during these episodes the individual not only makes choices between adaptive or maladaptive ways of dealing with his predicament but he also learns new coping skills. These may be healthy or unhealthy. He may therefore emerge from the crisis with improved competence, or he may become less competent and more vulnerable to future psychopathology. Also, during the disequilibrium of the crisis period the individual is more open to influence by others and more suggestible so that their intervention becomes more potent in moulding his attitudes and behaviour.

The recognition of these phenomena has led to the development of methods of crisis intervention by professional caregivers, such as educators, doctors, nurses, lawyers, and clergymen, to help persons in crisis and their families to work out adaptive health promoting ways of dealing with their life predicaments.[2]

PSYCHOSOCIAL SUPPORT

Psychosocial support is recognised more and more as being the most important factor in buffering the harmful effects of stress and privation in a population. The results of well controlled studies have shown that persons exposed to high levels of stress, who at that time receive particular types of support from others, do not have an increased risk of becoming physically or psychologically sick. Similar individuals exposed to similar levels of stress in the absence of such psychosocial support have a greatly increased likelihood of becoming ill.[4]

It seems that stress becomes pathogenic when it arouses negative emotions and their biochemical correlates; these in turn lead to a characteristic erosion of the capacity for problem solving. This renders the stressed individual less effective in dealing with his predicament, increasing the likelihood of a maladaptive response and the associated learning of mentally unhealthy patterns for the future. On the other hand, if during the stress the individual is supported by other people he is helped to keep his upset feelings in check and to increase his effectiveness. They offer him guidance in his efforts to cope, and they play an active part in sharing the tasks and burdens of his predicament. Together they are likely to find effective ways of mastering the difficulties so that health is restored.

This understanding has led to the development of methods of promoting or augmenting psychological support for people who are experiencing stressful predicaments, mainly by initiating and guiding the intervention of family, friends, neighbours, non-professional mutual help groups, and professional caregivers in the community.

The principles underlying programmes of prevention that deal with the protective variables of competence, crisis, and psychological support are, firstly, that professional caregivers should reach out to identify high risk subpopulations of individuals who are low in competence (perhaps because of age or because of poor education owing to poverty or prejudice), who are exposed to particular sorts of potentially pathogenic stress, and who have inadequate support; secondly, that they should use the methods of crisis intervention or encourage the provision of non-professional or professional support systems.[5]

Such programmes demand a proactive role from whoever tries to organise them. He must identify and contact target individuals and groups and monitor their adaptive efforts and the adequacy of their spontaneous efforts; and if he judges them to be inadequate he must intervene at that time. He cannot wait for the outcome; it may not be a healthy one, so that by then his intervention will be remedial rather than preventive. This raises the important issue of infringement of privacy and of the personal autonomy of individuals, who at that time may not feel a need for outside help. Moreover, since one important goal of such preventive intervention is to improve the reliance of the individual on his own resources, based on his expectation that he will eventually succeed in mastering his predicament, it would be counterproductive to be so active in helping him that he will emerge from the episode successful but more dependent than before. Of concern here are not only political and ethical questions of invasion of privacy and parentalism but also pragmatic professional issues about what kind of intervention actually leads to strengthening competence in a balanced way. But in many preventive programmes it has actually proved possible to work out methods for reaching out proactively and motivating target groups to receive guidance and support, which initially they were not aware that they needed.

Guidelines for the general practitioner

The following recommendations may be considered by a general practitioner who has decided to undertake a specific programme of prevention with the children of divorced parents.

(1) *Identify and monitor disturbance related to divorce*

The doctor should identify the children who have parents who are about to separate or divorce or have already done so. Thereafter, in any medical contacts he should hold a "watching brief," and he should let both parents know that he is available to them and their children for joint or individual counselling, guidance, or referral to a specialist. He should subsequently also be alert to the possibility that somatic complaints may be a manifestation of depression or hidden anger, especially in 9 to 13 year old children.

(2) *Proactive role*

The doctor has undertaken a mission to safeguard the health of these children. He should request the sanction of the parents to bring to their attention, whenever he sees fit, issues that he judges to be related to health, on the basis of scientific research reported in professional publications. He cannot force the parents to accept this service, but he should be clear about his willingness to offer them information and support if they wish.

Usually, when he sees the parents and the children and deems it appropriate to intervene they are likely to be in crisis because of some physical illness for which they are seeking his help. Thus they will be more likely to be amenable to his intervention and more easily influenced, as long as he is not heavy handed or overbearing and is sensitive to ambivalence in their responses to his offer of temporary support.

(3) *Build or reinforce a continuing supportive relationship*

A general practitioner does his work with a family over a period of years through occasional short contacts in response to their current feelings of need. He should inform divorced or divorcing parents that he expects them and their children to be involved in a lengthy readjustment of their family life which will continue over several years and that he will stay with them over the whole period. They are likely to have contact with him from time to time, mainly because of physical symptoms of illness. At any time they should feel free to consult him and ask for his guidance in these matters or in regard to problems of adjustment of parents or children to the divorce or its sequelae which not infrequently have medical implications. The doctor should watch for evidence that the children may be suffering from emotional distress or from learning difficulties owing to poor concentration or daydreaming, or for evidence that the custodial parent may be depressed and preoccupied and therefore may not be providing adequate support for the children. In our culture a feeling of depression and helplessness may engender a fear that asking for help indicates weakness of character. The doctor should emphasise that on the contrary it is a sign of strength, that ineffectiveness is a temporary manifestation of reaction to stress, and that accepting a helping hand at this juncture will usually lead to a rapid return to true autonomy.

(4) *Organise a joint interview with the parents*

As early as possible the doctor should invite each of the parents to come to his surgery together for a short interview. He should find out if they fully realise that, although divorce will end their marital relationship, it will present them with the continuing task of cooperating in sharing the parenting of their children throughout their childhood, irrespective of whom the children will live with. If they have not already agreed about custodial arrangements he should refer them to a conciliation service. He should also offer to talk about the divorce to the children alone or with the parents; sometimes children feel that there is nobody to whom they can talk and express their feelings.

(5) *Avoid partisanship*

The doctor should avoid being recruited as an ally by one of the

parents against the other. He should also avoid trying to elicit the "objective truth" when each partner tells a different story.

(6) *Support to parents in communicating with their children*

The doctor should encourage the parents, when they have decided on divorce, to meet jointly with their children and talk to them about it. The older the children the sooner they should arrange this meeting. If necessary the doctor should offer to be present at the meeting in case either of the parents needs his support in this.

The doctor should list the essential information that should be communicated during this talk, as follows: (a) The parents have decided to live apart because they cannot get along with each other. (b) The divorce is not caused by anything the children have done. (c) The divorce is a final separation. The children cannot change it or undo it. (d) The parents know that the children may not want them to split up, but this cannot be helped. (e) The parents promise that they will continue to love their children and that they will try to help each other take care of them. (f) The children will live with one of the parents but will be given the chance to meet as often as possible with the other parent because a child needs both a father and a mother. (g) The parents understand that the children probably feel sad, angry, and frightened, but they believe that they will succeed in helping the children master these feelings in time. (h) Most important and most difficult—the parents should allow the children to express their feelings openly, they should not try to "sugar over" the situation, denying or evading the difficulties. At the same time they should not force their children to confront all the negative implications and feelings too quickly; they should allow them to deal with the predicament a bit at a time and at their own pace; this will vary from child to child according to the age and maturity of each.

(7) *Doctor's role as a counsellor*

The doctor should aim at influencing the current behaviour of the parents by offering guidance and should not be concerned about any underlying reasons why they might have behaved differently if he had not intervened. He realises that he may be tipping the balance of a complicated set of psychological forces by exerting his influence on the final outcome. Among the issues he may wish to emphasise during his many contacts with the parents are the following:

(a) He should foster open communication between the parents about the children. They should avoid making use of the child as a channel of communication between them. Children tend to distort messages because of the intrusion of their fantasies. Parents should take their children's stories about each other with a large grain of salt. The child often tries to curry favour by telling each parent what he imagines he or she wants to hear about the other; he may take sides or may aggravate existing tensions to give himself a feeling of mastery to counteract his feelings of helplessness and insecurity because of the parental conflicts.

(b) The doctor should foster maximum access of the children to the non-domiciliary parent. He should emphasise the importance of each parent discouraging partisanship by the child to avoid the psychological damage that this will cause the child.

(c) He should urge both parents to talk well of each other to the children despite their antagonism to each other.

(d) He should continually focus the attention of parents on the current needs of their children, which he should observe and communicate to them if necessary.

(e) He should support the parents in catering to the emotional needs, especially of young children—for instance, the mother might take the child into her bed at night if he wakes frightened or insecure. But the doctor should warn her against using the child unduly to comfort herself or as a replacement for her absent spouse when she feels cold and lonely in bed.

(f) He should assure the parents that the sadness, anger, and regressive behaviour of their children is temporary, a reaction to their upset feelings because of the break up of their home. He should emphasise that such a reaction is normal, but he should monitor the behaviour of the children; if he identifies prolonged hold ups in their psychological development he should refer the children for investigation by a child psychiatrist or psychologist.

(g) Although the primary mission of the general practitioner is to safeguard the mental health of the children, he should also be concerned about the well being of their parents. He should encourage the parents to talk about their feelings of sadness, emptiness, and loneliness; these occur not uncommonly even after divorce from a hated spouse which was perhaps expected to usher in an era of happiness and freedom from care. He should be particularly alert to the occurrence of depression or related deterioration in physical health due to apathy in a domiciliary parent, especially one who did not initiate the divorce proceedings; he should counteract the underlying sense of failure and the loss of self esteem, and he should mobilise support by family and friends and mutual help by divorced persons in the neighbourhood who have succeeded in mastering a similar predicament.

(h) Eventually, the doctor may advise the parents about balancing the satisfaction of their own needs against focusing only on the needs of their children. He should offer them guidance on how to deal tactfully and discreetly with their children if they show heightened curiosity about the sex life of their parents. The children must not be allowed to dictate how the parents should lead their lives. On the other hand, the doctor should try to counteract any tendency of newly divorced parents to embark on a frenzy of sexual overactivity as an escape from sadness and mourning for a terminated relationship or as a denial of lowered self esteem because of the conjugal failure.

(8) *Indications for referral to a mental health specialist*

In addition to the possibility that the general practitioner may refer divorcing parents initially to a conciliation service (if they need help in working out an effective agreement regarding custody of their children and visiting arrangements) the following criteria should guide a decision to refer the family for investigation by a child psychologist or child psychiatrist:

(a) Signs of psychological disorder in one of the children—namely, enduring interruption in psychological development or clear psychopathology beyond expected temporary emotional or cognitive upset as a reaction to the crisis in the home. The psychological disorder may take the form of prolonged depression, scholastic failure, social isolation of more than three months' duration, inability to play, antisocial aggressive behaviour, delinquency, drug or alcohol abuse, sexual acting out in adolescent girls, or somatic symptoms that continue for more than a couple of months.

(b) Signs of a psychiatric disorder in a parent, particularly incapacitating depression, especially if accompanied by suicidal thoughts. It is usually "better to be safe than sorry."

(c) Abandonment of the children by one of the parents or a clear intention to do this. If at all possible such an eventuality should be dealt with in its early stages because once a parent has made a firm decision it is hard to undo; for the parents the immediate gain is great if it interrupts the stressful relationship between them. But the current effect on the children is usually bad, and the future effect may be worse.

(d) Compulsive recruitment of the child as a partisan, with an active campaign of vilification of the other parent and of brainwashing the child if this cannot be reduced by the doctor's appeals, based on his pointing out how much this is likely to damage the child. In certain cases, one or both parents seem to be locked into this destructive pattern and almost impervious to reasoned arguments. The earlier such cases can be dealt with by a psychiatrist or a psychologist the better, but even the most skilled specialist intervention often fails to solve the problem of this kind of enmeshment.

(e) Compulsive partisanship by a child, who passionately vilifies one of the parents and refuses contact with him or her.

(f) Major interference of the domiciliary parent in allowing the child access to the non-domiciliary parent in accordance with the divorce agreement. The criterion for referral to a specialist is the doctor's realisation that his own efforts to persuade the domiciliary

parent are proving unsuccessful, particularly when he is told that the opposition to visiting is coming from the child.

(g) Failure of the general practitioner to remedy harmful patterns of interaction in parents or children by his own counselling.

(9) *Supporting the supporter*

It is usually burdensome to persevere in providing support for ordinary people who are grappling with the kind of stress that characterises divorce. This applies even to mental health specialists who have been specifically trained in preventive techniques. It applies even more so to such generalist caregivers as family doctors. Unless they organise systematic support for themselves they soon get "burned out," and they retreat from the psychological "heat" of the preventive work.

The remedy is for the practitioner to establish a mutual support relationship with a colleague or group of colleagues, where each in turn rotates the roles of supportive adviser and supported advisee[6]; or, when things become too hot or too confusing, for the practitioner to request consultation from a mental health specialist, such as a child psychiatrist or psychologist or a senior welfare worker with specialist experience. The added benefit of using a specialist is that he can investigate the case if the consultation indicates that such an option may be appropriate.

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100 YEARS AGO

At the trial of what was known as the Bere Regis murder case at Winchester, Baron Huddleston is reported to have made once more some very outrageous remarks on medical men in general, and on the medical witnesses in the case in particular. We may mention that the prisoner, a young fellow, twenty-one years of age, was charged with murdering his grandmother. He is stated never to have been a person of strong intellect, and was on the point of leaving this country for Australia. His departure seems to have determined a fit of mental depression, during which he deliberately shot his grandmother, who had brought him up from a lad, through the head. He gave himself up to the police shortly afterwards. No motive could be assigned for the crime, as no dispute appears to have preceded the crime, and no attempt was made to take any money or valuables. The medical evidence was to the effect that the prisoner lacked apprehension, and could not realise his position or offence. This is indeed what one would have gathered from the evidence. We are ignorant of the exact nature of the circumstances which roused the presiding judge to anger, but he thought fit to pass some severe strictures on medical men, who, he said, "gloated over their scientific knowledge, and aired it in the witness box, where they would usurp the functions of the jury without taking a juryman's oath, and they excused themselves by saying they came to get a prisoner off." These are most extraordinary statements to fall from the lips of a judge, and we should be glad to be placed in possession of the exact details of the evidence and attitude of the medical man which gave rise to them. No doubt the situation of the medical adviser in cases like this is a difficult one, and requires no small amount of tact to place the facts in their proper light, and to avoid, at the same time, an appearance of dictating to the Court the conclusions they ought to arrive at. The inconvenience, however, is less the fault of the medical man than that of a vicious system. If any doubt exist as to the mental condition of a prisoner, the condition should be made the subject of enquiry by the order of the Court, which should delegate one or more experts to decide the question. To put a man on his trial before this all-important question has been settled is both barbarous and useless, since everything turns on the prisoner's sanity and consequent responsibility. Such a problem is not one which can be solved by a jury or even a judge, who are only called upon to offer an opinion on the credibility or otherwise of the medical man, a position obviously absurd and irrational, since it should be the duty of the Court to see that none but responsible opinions were admitted in evidence. It is absurd also to take the opinion of a jury, from which professional men are by law excluded, on the merits of a civil action for wrongful detention as a lunatic. It is high time these anomalies were put an end to by the establishment of an official board of referees, or other means by which the same end could be attained. What his lordship meant by medical men "gloating" over their knowledge, we are at a loss to imagine—they could hardly be expected or permitted to "gloat" over their ignorance. As to their "airing their knowledge in the witness-box," one might have been excused the impression that they were called upon to appear for that express purpose. If a medical opinion is not to command respect, it had better be dispensed with; but, inasmuch as we are by no means prepared to maintain that the opinion of every medical man is possessed of the same value, on so technical a subject, we would like to see provision made to obtain an opinion or opinions, in such cases, which could not be open to question. The prisoner was sentenced to death; but, as the jury appended a recommendation to mercy, it is sincerely to be hoped that the attention of the Home Secretary will be called to the desirability of investigating his mental condition, the inquiry on the next occasion to be conducted without incurring the risk of irrelevant, and even impertinent, remarks from anybody, even a judge. (*British Medical Journal* 1886;ii:990.)

A sanitary contemporary relates a very pretty little story about the employment of flies as sanitary inspectors, or rather inspectors of nuisances. In one of the rooms of a house, offensive odours were detected, but their exact source could not be located. Before proceeding to take up the entire floor for the purpose of ascertaining the *fons et origo foetoris*, it occurred to someone present to try the effect of introducing a couple of blue-bottle flies from the neighbouring stables. These sagacious insects, whose olfactory apparatus is apparently specially developed for stinks, soon settled upon one of the cracks in the floor, and, when the boards were raised at this point, a rat was discovered in an advanced state of decomposition. We are willing to admit that the suggestion reflected at least as much credit upon the person who made it, as upon the flies, who merely followed their animal instincts in preparing for a banquet, but when we have said this we have said all. No one would venture to maintain that this one solitary useful feature is a sufficient justification for the existence of the myriads of flies which, for the last week or two, have made the manufacture of adhesive fly-papers one of the few branches of industry exempt from the general depression which weighs like an incubus on commercial enterprise. The prevalence of flies, and the consequent intense discomfort of urban residents, shows a disposition to occur periodically, without its being possible to ascertain the occult laws which preside over the exercise of their extraordinary reproductive powers. We are, to some extent, worse off than the Egyptians of old; for whereas their plague of lice occurred once for all (vestiges of it may, it is true, still be found in their descendants), our plague of flies shows an unfortunate tendency to recur. They are, doubtless, endemic in certain quarters of London, notably in the immediate neighbourhood of parish dust-heaps, slaughter-houses, and sewage-farms, but just now they are ubiquitous and universal. The man with the fly-papers is looked for with more anxiety than the tax- or rent-collector, a fact which nothing short of the extreme discomfort implied by their company can explain. Like the wind, we know not whence they come, although, thanks to our advanced state of civilisation, we are enabled to state, with some degree of certainty, whither a good many of them go. Still, enough remain to make life a burden, and if some, or even one, of those erudite and painstaking gentlemen who write learned and interesting treatises on earth-worms and blackbeetles, would devote their attention to the genesis of flies, they or he would confer a boon on suffering humanity which would amply compensate for any lack of scientific interest in his researches and their results. If the development of these restless insects be any indication of faulty hygienic arrangements, then there must be something intensely rotten in the state of Denmark—or, rather, England—to account for so abnormal a proliferation. The wonderful procreative powers of the herring or the rabbit sink into a contemptible insignificance beside those of this insect. Let us, then, be up and doing; and since everything is done in this country by means of associations, let one be formed for their extermination. Doubtless, some gentleman with the happiness of his fellowbeings at heart, will consent to receive subscriptions for this purpose. (*British Medical Journal* 1886;ii:221.)