Emotional Problems in Childhood and Adolescence

Communication with Children and Parents

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Any statement regarding an emotional problem is an incomplete one. It may nevertheless be a perfectly clear statement. Here is an example: it was between doctor and doctor. A colleague consulted his general practitioner regarding an irritating cough which had lasted for over two weeks. The general practitioner arranged for him to have an x-ray examination. The following brief conversational exchanges have been numbered for convenience:

- (1) *Colleague*: "When will I get the result?"
- (2) *G.P.*: "In a couple of days. Have you lost weight recently?"
- (3) *Colleague*: "On the contrary!"
- (4) *G.P.*: "We will have to do something about that, won't we?"

The meanings go something like this:

- (1) "Is it something serious?"
- (2) "We shall let you know quite quickly. Are you thinking that you have cancer?"
- (3) "I can see now that it is not likely to be cancer."
- (4) "That's true, but we still have problems!"

In another example the meanings may not be so clear. A mother bringing her 6-year-old boy to the family doctor: "Doctor, he won't eat greens. He should, shouldn't he?" One meaning may reside in an isolated example of a food fad. Another possible meaning is: "Doctor, he won't do anything I tell him to do. My husband never supports me. If you give him a good talking to he would listen to you."

The question is, therefore, how explicit is it necessary to become to make the communication into a useful two-way process? The first requirement is to have a clear idea of what is meant by "emotional problem". An emotional problem may or may not be an illness and an illness may or may not be an emotional problem. The two terms are not synonymous. "Emotional problem" is a description and not a diagnosis. The essential feature is conflict (a) within the mental processes of a single individual (intrapsychic); and (b) between members of a family or other individuals (interpersonal). There are misuses of the words "emotional problem" when it is said, "He has a problem" in order to convey that someone's behaviour is undesirable. One has only to turn the phrase into "behaviour disorder" to imply that it is really a disease. The doctor is expected to cure it on that basis. This conceals another conflict—namely that of professional boundaries.

Relation to Development

Emotional problems are related to normal stages of development as well as to many of the abnormal situations concerning individuals and families. They are linked with childbirth (which imposes stress on mother, father, the newborn infant, and siblings), school entry, puberty, starting work, marriage etc; with acquiring special functions—for example, mastery of sphincter control, speech, educational skills (such as reading or mastery of number); the impact on the family and on the individual of illness, physical and mental defectiveness, and death of family members; and with the acquisition of the standards of the family and of society (that is, social adjustment).

Hence emotional problems are everybody's experience and everybody's business. There is much about emotional problems which is the special concern of the family doctor, but he is not the exclusive expert as he is with physical illness. Other people claim or are given a simultaneous responsibility: teachers, clergymen, guardians of the law, and the parents themselves. The doctor is an expert among competing experts and sometimes he is called on to act as the powerful agent of someone else who knows exactly what is wrong and how it should be put right, but who is unable to do it himself.

Thus the doctor himself has a problem. He is traditionally familiar with emotional problems associated with the emergencies in illness where he is in undisputed authority. He is now also expected to be expert in situations where the term "emotional problem" is one of several different ways of envisaging a situation.

Difficulties in behaviour and performance at school illustrate this¹:

For example, a friend has a six year old son at school. Like most six year olds, he won't sit down when you tell him to. The teacher tells my friend: "Mrs. v, your son has a problem. He's hyperactive." "Tell him you'll wring his little neck if he doesn't sit still," says my friend who has found this method works. "Oh no," comes the reply, "that would be terrible. That would give him a complex. We want him to fulfil his fullest potential. But he has a problem. . . ."

Here the problem is not so much that the doctor claims that this is his field. Rather it is allotted to him along with the demand that he should be successful in producing a desired result irrespective of the intellectual level of the child, the appropriateness of the educational techniques being used, and the family standards and expectations. Two solutions are implied in the above quotation, and the doctor does not have to accept either of them.

The doctor's successful participation depends on his being given permission to change the dimensions of the problem,² to make examinations and to ask questions about the problem, the child's personal history, and the family history. It also depends on his having within his own professional experience a framework which includes some knowledge of complex emotional interactions as well as his knowledge of physical medicine.

The doctor is not making a *professional* contribution if he accepts other people's communications at their own valuation without being able to bring in some new formulations related to his professional approach.

There is at the same time a considerable value in the contribution that comes from the *untrained* part of the doctor's personality: his wisdom and his personal experience of life. But this is the contribution that is justifiably held to be in competition with the contributions of others. Difficulties arise when the doctor fails to separate in his own mind those of his communications that come from his professional knowledge from those that come from his own experience as a child, as a parent, and as a lay member of the community.

The Interview

Young children are usually seen in the company of their parents. With adolescents some time should be spent with the adolescent alone.

The parents usually make the first communication. The doctor includes the child by his awareness of the child's anxiety and by the phrasing of his responses. The doctor's questions should centre at first on the main complaint. Further questions go only as far as necessary into the life of the child and the family interaction. As with physical complaints, the only probing is that which is required to make sense out of the complaint. Even if the first presentation is expressed in terms of physical symptoms, some anomaly gives the clue to the preponderance of emotional factors. In this case it is no more blameworthy to overlook physical illness than to overlook inner emotional distress. The best protection for the patient is the doctor's sensitivity to symptoms that fall outside the patterns of either physical or emotional disorder. In other words, emotional disorder is diagnosed on positive grounds and not on the exclusion of physical illness.

When exploring the field of emotional problems, interviewing and treatment are a single process. The manner of listening includes the ability to turn from parent to child and back to parent without having to pursue each line of inquiry to a predetermined conclusion. It is possible to change direction in response to cues in incidental information, and to carry thoughts back again into a main theme.

Parents whose children have emotional problems are often on the defensive. They expect to be accused of mistakes in the child's upbringing and may even provoke accusations in order to refute them. Such parents may never have been given approval for the goodness which they have given to their children, and be only too ready to keep the discussion on the level of a real or imagined badness.

Some responses of the doctor are the beginning of a guess which makes sense out of the apparently irrational. The guess when it finally takes shape is presented tentatively and not with the finality of a physical diagnosis. The doctor loses nothing if the guess is thrown back as inapplicable. Phrases begin, "Could it be . . . ?" or "Some people find that . . . ?". It then becomes something for the patient to accept and work with, or to refuse; and it is not a diagnosis by which the doctor's reputation is going to be judged. This method also has the advantage of demonstrating that emotional problems have at least two sides to them and they are not to be cured by finding a simple explanation. The problems remain problems, but the child and the family gain some additional viewpoints which help them to find new ways of coping.

The material which has been discussed involves facts of life and of death. Discussion of sexual functions has to take place without prudery, while maintaining respect for the diffidence and reservations to which the child and family are entitled. Where there is conflict or clash of interests between family members, the doctor is not the judge of which one is in the right. He is the representative of a viewpoint which has not yet found expression in any one of the individuals who form the conflicting group.

Referral to a Psychiatric Clinic

The family doctor sees more emotional problems than the psychiatrist. Like the teacher, the district nurse, and the health visitor, he sees the whole range of the population and becomes familiar with emotional reactions that are within the normal and becomes aware of reactions that go beyond. The decision to refer a child (or family) to a child psychiatric or child guidance clinic should be made when the problem still seems to contain irrational elements or where prolonged or specialized treatment seems to be necessary. The doctor should never say "we will try this medicine and if he is no better we will send you to the clinic." The cases which do best in the clinic are those where referral has been the first choice. If the patients ask "what will they do there?", the best short answer is "why not ask them when you get there?" At the clinic these questions form a natural part of the intercommunication, and if the doctor gives too long an explanation one of the family may be waiting to ask supplementary questions on the lines, "But how will that help?" If anything further is asked for, it is enough to say that "the psychiatrist will try to help you to sort things out?"

Attending a General Hospital

There is no substitute for the truth, but there are many versions of the truth. The child needs a full explanation of the experience that he himself is likely to undergo. Investigations and operations may be inevitable and not matters of choice. The child gives consent through his parents and as a token of his confidence in the sincerity of his doctor. He can be deceived only once; and yet children have been enticed into hospital for operations for acute conditions with the firm promise that it would be for observation and that there would be no operation. Operations have been done by stealth or by assault, and in just such a case a psychiatric consultation was subsequently arranged with the explanation that the psychiatrist was a specialist who would look at the boy's feet. The boy's anger at the psychiatrist was fully justified, even if slightly misplaced. All investigations are an intrusion on the privacy and integrity of the body. They should be restricted to what is relevant.

Being Handicapped

It is difficult enough to communicate with parents about physical or mental handicap in their children. The parents cannot come to terms with the potentialities and limitations of their handicapped child until they have mourned the loss of the perfect child (of their imagination) for whom the handicapped child is an inadequate substitute. The parents must be allowed to suffer the grief for their loss and to make preparation in their minds for the burden that is going to be with them as long as they live. The doctor needs to be constantly aware of the parents' anxiety for the care of the handicapped adult who may survive after their death.

The handicapped child gets some image of himself from the apprehensions and hopes of the parent. There are popular and professional stereotypes of handicap. In some cases physical handicap is preferred to mental handicap—it seems to carry less stigma. But even with physical handicap some members of the public look away in case the disability is catching. Popular stereotypes of mental handicap are often self-contradictory. These children may be thought of as perpetually helpless and dependent, or dangerously adventuresome and aggressive. Sexual activity for the mentally handicapped—whether masturbatory, homosexual, or heterosexual—is abhorrent to some people, even though there is enlightened clamour for maintaining the mentally handicapped at home and in the community. It would be unreal to break down the walls of the closed institutions unless there can be toleration for expression of intellectual, occupational, and emotional fulfilment to the full extent of each handicapped person's capacity.

Communication with the handicapped individual is possible if the doctor can wait for a response from the child. There are some simple themes, comparable with those in young children of average performance and mental ability. Progress does not take place from pressing the child to carry out activities in which he is bound to fail. It comes from the satisfaction given when the main contribution from the doctor, the teacher, or the parent, to a child's chaotic production, turns it into sense. A single line added to a drawing, a simple addition to a model, or a single word which turns the child's jumbled sounds into a meaningful phrase—all these are implements of growth and a confirmation of the child's inner worth. A perfect model for the child to copy would be a proof of the child's defectiveness. The main themes are truthfulness, and refusal to give a complete and perfect pattern as an example to be followed. It has to be recognized that handicap is a handicap and that it does not have to be overcome.

Death

Discussion of death seems to be the ultimate taboo, even in a society which has learnt some freedom of expression about sex. Most explanations of death assume that it occurs only in old age. Death in early adult life and in childhood is too painful to contemplate and yet it is part of ordinary experience. The doctor's special responsibility is to attend some of the illnesses in which appropriate diagnosis and treatment can avert death, but he is also expected to continue in attendance in those cases where, in the nature of the illness, death is inevitable. There are also the deaths by violence and by accident. Even in those cases where the circumstances leading to the death can be scientifically understood, there is still the question, "why should it be this person, or that person, and not someone else?"

Death releases complex emotions in long illnesses. Some anticipatory mourning has already taken place, and it is with a feeling of guilt that people feel some relief from the burden of the care. The doctor should be aware of the existence of emotion which is opposite to the one expressed. When it is relief that is spoken of a comment can be made, "but in some ways you will miss all the care that you have had to give." When the grief goes on being expressed, one should be aware of the anger that may be felt, against relatives, the doctor himself, and a universe which makes these things possible. Some people find comfort in religion, but it should not be forced upon them. There is a saying in the Talmud, "Never console a mourner in the presence of his dead."

With a child who is aware of facing a 50% chance of inheriting Friedreich's ataxia, there was no scientific reassurance. In one particular case I asked a child, "Do you have a special night prayer?" The child merely nodded. "What is it?" I asked. There was no reply. "Is it a secret between you and Jesus?" For the first time, the child smiled.

Children are given insufficient credit for noticing the disturbances and misfortunes in the family. Deaths of grandparents and other relatives may be concealed from the child for a considerable time "in order not to upset them." Cases are known where a pet dies and an attempt is made to replace the pet before the child has been told of the loss. Concealments devalue the importance of the child's feelings and the importance of the identity of what has been lost.

Children need their normal grief. No one can value his own self unless he can grieve for the loss of someone else. The person who has to carry the information may be afraid of the emotional impact at the moment of communication and may shirk the job. With bereavement, as with information about illnesses and handicap, the doctor has to be aware of his own feelings and need not attempt to hide the tears that come unbidden to his eyes.

Two Levels of Decision: Opening and Closing

The communications between doctor and the family lead to a

decision which is the course for action. The choice somewhat resembles that in acute surgery. Here the choice may be whether to open up, to explore and, if necessary, to drain away the infection; or to take the alternative in which the natural processes in the body can be expected to deal with infection without any further intervention. Training and experience helps the family doctor to take part in these choices.

There are many other kinds of problem in which the family doctor makes a closing decision or opens something up.

The *closing decision* is often expressed indirectly, somewhat in this fashion: "Take this medicine and come back in a fortnight." The patient realizes that no further communication is necessary until the instructions have been carried out. It is a similar decision to say "I am going to arrange this treatment and we will see how it works out." These decisions are part of the skill of the doctor. It is assumed that he has taken into consideration all the relevant data and, without unnecessary words, he conveys his confidence to the patient.

Closing decisions are seen most clearly in the minor physical ailments where the treatment which is chosen is expected to be effective. Even with the physical ailments, the patient's knowledge that the doctor has taken command is a help to the natural forces of recovery. The accompanying anxieties have been relieved. The patient feels better, even before the first dose of the prescribed drug.

Something similar happens with emotional problems whenever the doctor can offer reassurance based on knowledge that the emotional distress is a perfectly reasonable reaction to incidents in the patient's life cycle.

Opening decisions with regard to emotional problems imply questions about personal and family interaction. Here, too, the communication may be part of a therapeutic process, but many of the replies may be a surprise jointly to doctor and the individual patient or family. When the patient returns for the next interview, the doctor does not ask, "How have you been?" If he did, it would imply that the patient's progress would be related solely to the events in the previous interview. Instead, he asks "Were there any other things that you thought of after you left me last time?" This implies that the patient is taking some of the responsibility for working on his emotional problems, even in his absence from the doctor.

The Doctor as Carrier of Standards

Preventive work, in the sense of providing positive contributions towards mental health, comes from some of the doctor's attitudes to the normal processes of development. Emotional problems are not separable from the normality of the individual in the way that organic illness is. Problems are seen as an interaction between the developmental processes and some specific aspect of experience.

The doctor reveals his attitudes to infant feeding; breast *v.* bottle, flexible *v.* feeding times; toilet training; punishment for bad behaviour; recreation and sleeping times; and sexual development. His views are expressed in phrases which families accept and preserve as a private possession. His words enter into legends which help families to maintain their standards. The doctor conveys the right of each family to reassurance when that is justified, and to any painful truths which are inescapable, but he does not completely deny them hope.

The doctor has to continue to deal with intractable cases (physical and mental) which no one can cure, even when they pass in and out of the hospital system and up and down the hierarchical scale of specialist treatments. In the last resort these cases always remain with the general practitioner, who has to be aware of the emotional impact on his own person.

References

- 1 Brandon, Ruth. *New Society*, 1972, 20, No. 498, p. 71.
- 2 Kahn, J. H., *Human Growth and Development of Personality*, 2nd. edn., p. 1-9. Oxford, Pergamon Press, 1971.