Emotional Problems of Childhood and Adolescence

Handicapped Pre-School Children and their Families — Effects on Child's Early Emotional Development

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As well as the known responses of the infant to the amount of warmth, empathy, efficiency, and control shown by the mother,¹ attention must be given to the quality of response from the child. The degree of activity, passivity, positive versus negative mood, ease of stimulation against difficulty of arousal, regularity versus irregularity, considerably affects the mother's response.² Problems which children have with particular handicaps may well in their turn specifically affect aspects of their development and their parent's attitude towards them.

Handicap and Response

Though the blind child smiles at six weeks he does so less frequently and in response to touch rather than sight.³ He cannot reach out and use his hand to locate objects, but has to wait to be touched by them. So that undersanding of the world and particularly the definition of the self from the other cannot be reached through normal integration of sensations coming from hand, eye, and mouth.⁴ Such difficulties mean that the blind child may prefer to rely on body stimulation and movement for pleasure—rocking, twisting, thumb sucking—rather than through the manipulation of objects, essential to the sort of play which leads to adaptation, control, symbolization, and learning about the world. The unknown is dangerous. The familiar provides reassurance for any child deprived of information about his environment—whether he is blind, deaf, autistic, or has cerebral palsy, spina bifida with difficulties in manipulating, moving and exploring, or is retarded with little interest or drive to explore.

For all these children a predictable routine of feeding and pleasure in body stimulation and body care by the mother may be more comforting and rewarding than the precariously controllable challenge of new situations. Such a routine may well be clung to in an obsessively rigid manner and is found to be an important aspect of the emotional development of blind and sensorily deprived children. As a result there may be strong resistance to the move from being fed to self feeding, use of the pot instead of napkins. Being left in a play group may result in clinging, and overdependence with restricted social contact with other adults and children. Instead of meeting the mother's failures of adaptation with powerful forward moves the drive may be directed towards a struggle for control, sameness, and fixation to immature patterns of functioning.

Such rigid patterns can be altered by the appropriate inter-

vention and stimulation,⁴ but the parent who expects cues from the child about his readiness for the next step may become confused, discouraged, and anxious and may give up trying.

A similar situation may arise if unresolved parental feelings of hostility or fears of having caused the damage lead to over-protective attitudes, and attempts to prevent further harm. Too much care or "too-perfect" adaption to the child's needs mean that failure is not provided and the child is over-controlled, becomes over-dependent and infantile, and unable to respond to the stress inherent in development.

Effects on Formation of Early Relationships

Paradoxically the achievement of a satisfactory degree of independence depends on the quality of the primary attachment between mother and child, and out of this comes a secure sense of identity and confidence in the world outside. During primary attachment a complete picture is built up of the mother in the infant's mind and he has to become aware of her many different aspects. She is experienced as a combination of the sight, sound, voice, warmth, smell, the feel of her skin, hair, mouth, lips. As a source of comfort, at one time and of frustration at another, she is seen, as two people at first, but later, through the growth of transitional phenomena and memory, as a whole person. Mothers can normally help their children through the anxiety and panic of this process. Nevertheless, if she is preoccupied, depressed, and grieving she may be experienced as a predominantly frustrating, uncomfortable figure and the child may turn away from her—not feeding, failing to thrive, crying, not sleeping, or may turn to himself, with rocking and self stimulation.

For the child with some sensory component missing—for example, sight—there may be no relief from mother's angry word by the sight of her smile afterwards. Thus blind children do not maintain the idea of their parents as a constant object in their minds until a later period than normal.⁴ This means that with their need for sameness and security the blind child may inhibit the normal show of assertiveness or aggressiveness for fear of provoking a frightening, punitive idea of his mother or father. The result may be a conforming, over-good child who is passive and lacking in maturity with negative feelings underground.

Although the deaf child⁵ has vision intact, he may fail to develop the ability to communicate verbally. Ample reasons can arise for parents to feel frustrated and discouraged and for the child deprived of the transitional phenomena of sound, names, tunes, and stories to feel insecure. Children with similar language problems—whether from deafness, developmental language problems, autism, or severe deprivation—are handicapped in these respects, and in their later educational potential which is tied to verbal skills.

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RESULTS OF FAILURE

The failure to integrate and comprehend verbally means that frustration may be poorly tolerated. Instead of the "conforming" response of the blind child, there may be an explosive reaction. With the restriction of comforting communication, fantasy, and memory, an attempt is made to get rid of the source of frustration. Normal failures of adaptation are greeted with rage and tantrums; the birth of a sibling, changes of routine, admission to hospital, or separation (with the absence of mother) may be overwhelming and incomprehensible and lead to violent outbursts. In his egocentric view of himself there may be long-standing resentment at the relationship the parents have together or with a sibling. He may find sharing difficult and try to control the family. Socialization, toilet training may become a battleground. Attacks may be directed against the self, biting and scratching.

Similar problems may be seen in the brain-damaged or epileptic child, who has poor impulse control in response to frustration. If such difficulties are combined with overactivity and short attention span parents may find their child particularly hard to cope with, and may provoke considerable strain and hostility. A vicious circle can result with problems spiralling. There is a danger of such hostility and negativism becoming the main language for communication. The rejected child who fails to get his needs met normally, may use similar mechanisms—a smack being as good as a hug in meeting his needs for recognition. The pre-school handicapped child in hospital without his mother has similar feelings. Stay in hospital and posthospitalization responses of protest, despair, withdrawal, and apathy (with regression in socialization, clinging, fears, and distress) should be well enough known to be prevented by adequate visiting, rooms for mothers and child-centred nursing.

The Severely Handicapped Child

The multiple handicapped child may have a combination of such problems. The child with rubella who is both deaf and blind may have such problems in synthesis and comprehension of the world that he fails to make a primary attachment to one person. A state resembling autism may develop with self-isolation, bizarre stereotyped behaviour, and self-stimulation and aloofness. Any severe impairment in communication together with severe environmental deprivation—material or emotional—may result in a similar "autistic" state.

The moderately or severely retarded child may present with several problems. These children and their parents appear to evoke a much less sympathetic response from the community than the physically handicapped. There may be greater tendencies to become frustrated and rejecting at the slow pace of development, with patterns emerging as described above. What may start as a difficulty—for example, gaining bowel and bladder control—can become a battleground. Alternatively, there may be a tendency to deny the slowness of development, as it may unfold relatively normally in sequence, problems then arising of acceptance of differences as school age approaches. Severely handicapped children are far more likely to be found among those placed in long-term residential institutions.

Emotional Problems of the Older Pre-school Child

The tasks to be accomplished by the older child are in the areas of sex definition and role in the community at large. There is the problem of finding an appropriate sexual identity. Long-standing contact with mother involving close body-care over a prolonged period may mean that the boy may tend to adopt a feminine role rather than an assertive masculine one. The rigid, passive attitude also favours a feminine identification. Frequent surgical or medical procedures—or the use

of appliances, calipers, urinary bags—may also provoke feelings of being damaged or mutilated and this too may emphasize feelings of being different. The girl may feel she will never be a mother and the boy never a father.

Attitudes to hospital may play an important part in general adjustment. On the one hand, there may be excess attachment to a nursing sister seen as the real mother, while the true one is rejected. On the other, there may be excess phobic anxiety when any hospital contact is necessary—with nightmares, clinging, and misery following each visit.

In making contact with other children the handicapped child may use his appliance or special diet to gain prestige, but he may meet rejection, fear, and disgust, and not find acceptance. Where physical excellence and skills are a sign of status the handicapped child feels a failure. He may talk a great deal about aggression, without entering the rough and tumble. He may instead focus on his body and its shortcomings, and feel ugly, useless, and in need of care from his mother instead of facing competition from his father and the other children.

Handicapped Child and Family Functioning

With increasing emphasis on the "therapeutic" skills of the parent in helping their handicapped child, it may well be asked whether there is a risk from such intense involvement, from the prolonged period of primary maternal preoccupation. The rewards can be considerable for the mother who helps her partially hearing or deaf child to speak, her visually handicapped child to gain confidence in his world, the child with cerebral palsy to move sufficiently to gain concepts of space and size, or the mentally handicapped child to reach simple skills and self-help. With the aid of voluntary societies parents often become expert concerning their child and his special problems, and may even rival his medical advisers in the community. There may be an unwitting response and a danger of breakdown of communications.

Some parents have such an intimate knowledge of their child that they develop a special mutual non-verbal communication. Strangers are not felt to possess this ability and the parent may not wish to entrust his child to them. In this "too perfect" adaptation or "too-good mothering" there is a failure to appreciate that some degree of frustration is essential for a child to feel it necessary to communicate through speech, and to extend his social contact. Overprotection, overinvolvement, and overdependency may all occur. In some families the mother may well be aware of such a danger, but then finds her attempts to encourage independence undermined, and labelled cruel, by her own mother who cannot allow herself to be as demanding. Instead of support and help in being firm, they condone making up for the child's impairment by spoiling.

FAMILY STRESS

Preoccupation with a handicapped child may well come to exclude, or be felt as excluding, the other parent or sibling, and stress in a marriage or a family may be very greatly increased. Professional help should be aimed at helping the child gain sufficient independence to relieve the family's strain. Special baby-sitting arrangements, nurseries, or day-care relieve the pressure. Periods away from the family may appear an attractive solution. But the families' guilt felt at the fulfilment of hidden rejecting wishes may result in unpredictable somatic and psychiatric symptoms—particularly depression—and there can be permanent rejection. Coping with separation for an immature child may result in severe problems when reunited with the family; increasing clinging, tantrums and regression in social skills.

Schaffer⁷ has described the "too cohesive family," where not only the mother's life but also the father's and siblings

becomes excessively centred on the handicapped child, to the detriment of the emotional growth and functioning of the family unit. This appears to be a way of avoiding damaging conflict and tension. It is possible for the normal sibling to become deprived as so much attention is given to the handicapped child. The normal child may respond with aggressive, attention-seeking behaviour. The birth of a handicapped child can become a factor in the distortion of the general family relationships. There may be a diversion of feelings and scapegoating of the normal sibling, who can be rejected where the handicapped child cannot. Consequently he may feel it was his fault, expect punishment, provoke it, or become anxious or depressed.

GENETIC COUNSELLING

Frequently parents limit the size of their family after the birth of a handicapped child, not always on realistic grounds. The importance of genetic counselling to clarify such problems may require several consultations and "working through" particularly if there is a high genetic loading—for example, phenylketonuria or haemophilia. Marital and family tensions can develop in looking for the blame. Where the family "mourning" is resolved by defining the handicapped child as needing indulgence, a sibling may be encouraged not to hit back, if attacked inappropriately.

All this may convince the handicapped child that he is always right, maintain his ideas of omnipotence and egocentricity and prevent the development of an empathic appreciation for the feelings and needs of others. Frustration is reacted to with justified aggressive outburst. Alternately with the urge to make sense of his own state of existence, his pain, discomfort, clumsiness, stiffness, or failure to comprehend or to be understood, he may attribute his difficulties to actions of parents and other children in the family or to his own "badness." This may lead to a variety of symptoms—aggressiveness, fears, and obsessiveness.

Intervention in Emotional Problems

With the vulnerability of the pre-school handicapped child, above all, prevention is more important than cure. He should remain with his parents rather than be separated for specific educational help at 2 years. For a child without parents the substitution of a foster home or family group home is preferable to an institutional placement. Separation for medical intervention should be reduced to the minimum and parents should accompany their children whenever possible. Facilities have to be made available not only for the child with a specific handicap but also to help the family to participate in the process of treatment and to prevent the emotional problems which can arise with greater frequency among these children.⁶ To achieve this a professional team is necessary and in the first place the paediatric clinic and the district assessment centre should fulfil the task. At a later date the community of general practitioner, welfare clinic, social services, and voluntary society has to provide the containing functions.

PRESENTATIONS

Emotional problems may present in several different ways. They may be noted by the teacher of the deaf, or the blind, the speech therapist, or physiotherapist—who comes across unexpected delays in learning or may be aware of mother's inability to co-operate in the therapeutic work with the child, or of tension between them. The family doctor, paediatrician or infant welfare clinic, or medical social worker may be

presented with a child's management problem or come across the problem secondarily for psychiatric symptoms in the parent or another child, or in evaluating marital discord.

The health visitor or local authority social worker concerned with families at risk may note the quality of the relationship as it develops between child and mother and also be faced with problems within them or in the family. They may also be faced by requests to find a residential placement for a child who is rejected.

Each of these groups need to be aware of the nature of the child's and family's potential range of response so that appropriate treatment can be carried out. The "crisis intervention" model of help^{8,9} seems of particular value here, as complaint frequently arises when coping methods previously devised by the parent, child, and family to deal with the problems are breaking down. An opportunity then arises to ventilate feelings which have been unresolved over a long time and have them understood in an empathic, non-critical accepting way. More healthy coping methods may then become possible. In some families rejecting, hostile feelings towards the child are often most feared and difficult to admit to, but if faced and coped with can produce most relief. In contrast for the rejecting parent the loving affectionate feelings are often the hardest to find, as they confuse the initial request of wanting a child out of the family.

The value of seeing *both* parents when a crisis arises is often not recognized, and in some families seeing the unaffected siblings or grandparents may reveal unexpected sources of problems or of strength. In this way it is possible to clarify confusion and distortions which can affect the whole family functioning and well-being. One member—a mother, the child, or sibling—may be found to be carrying the grief and distress for the whole family, which if shared can be less of a burden.

INTERPROFESSIONAL CO-OPERATION

The group of professional workers involved with the family may also find additional strength in meeting to consider the family's needs and by co-operating rather than allowing themselves to be split and divided by the family or their professional roles. The regular clinic with a number of mothers attending can provide an informal "extended" family for certain mothers and children. This mutual support has extended to the growth of voluntary societies—whether for autism, cystic fibrosis, mentally handicapped, spastics, spina bifida, rubella, blindness, deafness. Such organizations can help channel the powerful feelings aroused in the families to constructive reparative ends, whether through facilities provided or research supported, meeting the needs to do something. There is a risk that in finding such an expression for grief and mourning, certain less obvious personal aspects of reactions may be avoided.

PRE-SCHOOL FACILITIES

So far as the children are concerned the provision of adequate pre-school facilities is vital in prevention and dealing with difficulties as they arise. The pre-school play group principle, with the mother participating *alongside* staff, is a useful concept, and there may be a case for the mixing of normal and handicapped children at this young age. In the day centre for pre-school children attached to the Department of Psychological Medicine at the Hospital for Sick Children it has been found preferable to mix intellectually handicapped together with non-handicapped children with severe emotional problems. As well as the informal support gained from the communal staff-parent-child play-activity groups, individual or group case-work or therapy with particular mothers and children is possible. Behaviour modification techniques can

be used to control unwanted behaviour and encourage specific skills. Group work with the parents can be conducted—parents confronting and being confronted with both the impact of the child on themselves, and the effect of their attitudes on their children's behaviour—while individual therapy can help children or parents to understand their feelings or reactions.

Parents' groups¹⁰ are being conducted in several centres with a variety of problems, and this may be a method of giving support and understanding when current and future crises occur before they become intense.

Finally, drugs may be needed for the brain-damaged over-active impulsive child. As the child approaches school age the parent may have to face the necessity for special education. They once more become aware of the discrepancy between their expectations and reality. With adequate pre-school educational provisions, and satisfactory solutions of earlier crises it should be possible for the transition to be less pain-

ful. Physical or mental impairment should not handicap the future emotional adjustment and development of the child.

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Second Opinion, Please

Contraception and Infertility

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DR. OLDERSHAW:

Nearly 20 years ago, when I was the new young doctor in the practice, one of my first visits was to Brenda, a bright-eyed child of 6, who had just returned home after hospital treatment for tuberculous meningitis. Fortunately, she made an apparently complete recovery, and as the years went by, I was needed to treat nothing more serious than colds and 'flu.

At 19 she got engaged and sought my advice on contraception. She wanted to try the pill. I knew her past history and that of her family, and there seemed no contraindications. She had a regular 28-day cycle lasting four days, with slight first-day dysmenorrhoea and a moderate loss. Physical examination revealed no abnormality. Brenda and her husband planned to wait two or three years before starting a family, and the three of us agreed that oral contraception seemed the ideal method. Three months before her wedding she started taking the pill and suffered minimal initial side effects. The duration of bleeding was reduced by one day and the dysmenorrhoea vanished. A full pelvic examination and cervical smear shortly after her marriage were entirely normal and she continued to take the pill for three years. During this time she attended my surgery every three months to report progress, and also to have the opportunity to discuss anything concerning oral contraception that she had heard of, or read about, in the popular press. Once a year she had a check-up comprising urinalysis, blood pressure recording, examination of abdomen, breasts, pelvis and leg veins, and a cervical smear. No abnormality was detected on any occasion.

The couple decided the time had come to start a family. Brenda now 22 years-old stopped the pill, had a withdrawal bleed, and a normal, slightly painful period arrived six weeks later. Her former 28-day cycle returned and I told her to return to see me if she thought she was pregnant or if she was not pregnant within six months. I took this opportunity of explaining to her that intercourse between the 12th and 14th days of a 28-day cycle, coinciding with the date of expected ovulation, offered the best chance of pregnancy.

Her periods continued to appear and after six months she returned. The couple were having intercourse three times a week and in my experience failure to conceive with frequent intercourse in mid-cycle should be investigated by the general practitioner after six months. Often something is wrong, and even if it is not, the feeling that "something is being done" goes a long way to avoiding the anxiety and depression which soon follow the disappointing menstrual regularity. As her dysmenorrhoea had returned after stopping the pill, I was pretty sure she was ovulating, but I showed her how to read a clinical thermometer and how to keep a chart of her early morning temperature. Three months later we had a chart showing a typical ovulatory rise on the 14th day of each cycle, but still no pregnancy.

I refuse to allow my female patients to undergo what I consider to be potentially dangerous hospital investigations until the male, who is the cause of the difficulty in one-third of the cases, has been investigated. On the other hand, I find that many husbands object to being investigated at all, and most dislike producing specimens for seminal analysis. A postcoital test, which can easily be performed in the surgery, is the ideal way of solving this problem. I find it is better for the husband not to know anything about it until afterwards, as I have known impotence to occur after a doctor's instructions to have intercourse on a certain day. Accordingly, I asked Brenda to use her feminine wiles to arrange for intercourse to occur on the 12th night of the cycle, not to have a bath afterwards, and to come to see me at midday the next day. Brenda's wiles worked perfectly and 14 hours after intercourse I removed the cervical plug of

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