Psychosocial Pediatrics

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CHILD CARE (s. DAY CARE, NURSERY SCHOOL, BABYSITTING)

- child is regularly cared for part of day or night by **someone other than his parent**.

Types of child care

A) Intrafamilial arrangements - other members (incl. older school-age children) of immediate or extended family care for child.
B) Care in child's own home - by nonfamily employee (e.g. baby-sitter, nanny).
C) Family-run child care homes - 6 or more children are cared for in private caregiver's home.
D) Center-based child care - relatively large centers where professional staff care for ≥ 13 children.

Impact of early child care

- *poor attachment to mother* → later emotional problems.
  N.B. **no clear evidence of actual emotional damage** referable to early day care in controlled, longitudinal studies - emotional outcome is no worse than home care with at-home mother.
- beneficial social effects - children become *more socially competent*.
- **cognitive benefits** (most marked in deprived and socially at-risk children) - make academic achievement more likely.
- decreased risk for *child abuse/neglect*.
- promotion of **optimal health behaviors** (e.g. staff can monitor immunization status).
- children in group day care are significantly more likely to experience *infectious illnesses*; most center-based and many family-based child care programs do not allow ill children to be present (40% of parental work absences are result of children's illnesses).

FOSTER CARE

- safe, temporary placement for child who is at social, emotional, or physical risk.

- 0.4-0.5% children in United States are in foster care.
- most common reasons in past: extreme poverty, absence / death of parents, severe chronic disease or mental retardation.
- most common reasons nowadays: neglect, abuse, parental AIDS*, parental substance abuse.
  *27% children whose parents are infected with HIV are in foster care
- increasing numbers of children remain in foster care for ***prolonged periods*** and later in life.
- among foster children, minorities are highly overrepresented.
- **boys** > girls.
- 20-30% foster children who go back to their families are **returned to foster care** (50% return within 30 days).
- 15% foster children are adopted.

Types of Foster Arrangement:

Type of Foster Home	Advantages	Disadvantages
Extended family (kinship care)	Familiarity to child	Risk for similar pathology as parents
Group homes	Highly specialized for special-needs children	Expense and availability
Private foster homes	Often highly dedicated	Availability; depends on adequacy of screening

Problems of children in foster care

1) high incidence of failure to thrive, developmental delay, behavioral problems, and psychiatric disorders.
2) less likely to have defined, constant source of **primary health care**; H: **"medical passport"** - continuously updated medical record that accompanies foster child.
3) 40-76% foster children have ***chronic medical problems*** (esp. dental, visual, hearing, allergy, asthma) that are often inadequately addressed.
4) higher incidence of **conduct problems and assault** (reflect preplacement abuse and psychological disturbance rather than result of foster care).

ADOPTION

- 2-3% children in USA are adopted: 2/3 are adopted by related family, 1/3 by people outside family.
- decreasing availability of adoptees (esp. younger children):
  1) greater use of **contraception** and **abortion**
  2) changes in societal **attitudes about illegitimacy**: more children born out of wedlock are kept by biologic parents.
  3) improved financial and nutritional **support for single mothers and lower socioeconomic status mothers**
  4) birth rate growth is highest in **inner-city families** (support children of single mothers within **extended family system** rather than give up children to adoption).
- increased divorce rate → ↑children are adopted by step-parent spouse of biologic parent who has sole custody.
- greater proportion of available adoptees are older, of mixed racial backgrounds, from foreign countries, at high medical risk, or have special developmental or emotional needs.
- **special health issues** exist for these children (mostly infectious diseases - hepatitis B, tuberculosis, pathogenic intestinal parasites).
- increasing numbers of **older / single adults** seek children for adoption.
- odds for adopted boys having psychiatric problems are 2.28 times higher than for boys who are not adopted; **origins** of increased psychiatric problems **are unclear.**
  – adoptive family issues appear not to play role.
  – factors implicated include *adoption later in childhood*, *identity and developmental stage issues*, and *biologic family mental health history*.
- **IQ scores and school attainment** appear to be as good as for non-adopted children (actually higher than expected from biologic parents' profile).
- ***information on medical status*** of child should be compiled and discussed with adoptive family (thorough health assessment, including behavioral and developmental status, is essential);
  – routine screens: hepatitis B [esp. if child is Asian or biologic mother is positive], tuberculosis, intestinal parasites; routine HIV screening is not indicated.

Dilemma of **"when to tell"** child about adoptive status.

- best age is **2-3 years**, despite limited understanding during preoperational period; being told that he / she was "chosen" is taken positively by child and may allow for better adjustment during next period.
- at **school age** (concrete operations period), child is better **able to comprehend "being given up"** → feelings of being unworthy or different, worries about change, disruption, and intrusion by biologic parents.
- during **late school age / adolescence**, learning of adoption for first time may magnify normal adolescent issues of ambivalence toward and relative alienation from adoptive parents.

DIVORCE

family aspects → see p. Psy1 >>

Aggressive and delinquent behavior, poor adaptation, depression are increased in children of divorce – due to decreased parental monitoring of child's behavior and ongoing parental discord, not divorce itself.

- older child at time of divorce, greater chance of negative outcome.
- this pattern is not seen in children whose parents die.
- ***continued parental hostility toward each other*** is single strongest predictor of long-term maladjustment for children of divorce.

Acute age-related MANIFESTATIONS of divorce:

Age Period	Manifestations
Preschool (2-4 years)	Regressive behaviors: sleep instability, tantrums, separation resistance, bowel/bladder problems, increased need for attention. Egocentric sense of guilt/responsibility.
Early to mid school-aged (5-8 years)	Overt depressive behavior, open grieving, fear of being replaced, deterioration of peer relationships, phobias
Late school-aged, early adolescence (9-13 years)	Anger directed at parents, blame and recrimination about parents "not having done enough" to avoid divorce, school and peer problems
Adolescence (14-18 years)	Exaggeration of adolescent issues: insecurity, loneliness, social isolation, depression. Magnified acting out: school failure, truancy, criminal behavior, substance abuse, pregnancy

Patterns of CUSTODY in divorce settlements:

Type	Description	Advantages	Disadvantages	Comments
Sole	One parent has exclusive legal responsibility and physical custody; visitation and some financial child support may be ordered by courts	Less potential contact between parents; less emotional entrapment for child	Higher risk of fewer financial resources for child and custody parent (mother); high risk for lost contact with other parent (father)	Sole custodian is mother 75-90% of time; boys do less well if mother is sole custodian; decreased contact with other parent may lead to long-term emotional problems for child
Joint legal	Both parents share legal responsibility; one parent often has primary physical custody (mother); other parent has more contact than in sole custody	Less risk of financial deterioration for child; more contact with other parent (father)	More contact between parents; more risk for emotional entrapment of child	Works best when there is "amiable" divorce
Joint physical	Both parents (in principle) share 50-50 physical custody	Less risk of financial deterioration; continued contact with both parents	Maximal contact between parents; possible disruption of child's daily or weekly routine	Requires significant cooperation between parents

Advice to parents about informing child of impending divorce:

- consider developmental stage of child when *choosing words* to explain situation.
- reinforce and reassure child that *all that could be done* to keep marriage together *has been done*.
- repeatedly assure child that he will be safe and *will not be alone*, and that everything possible will be done to keep familiar, reassuring things unchanged.
- *avoid undermining other parent* in child's mind.

MALFORMED INFANT

- tragedy that creates complex challenge for pediatrician who must care for child and help parents.

Stages of parental reaction:

1. Shock
2. Denial
3. Sadness and anger
4. Reorganization and acceptance

Supportive actions:

1) infant should be shown to parents as soon as possible (mental image of anomaly is often worse than actual malformation).
2) encourage parents to spend as much time as possible with infant.
3) convey information in truthful manner.
4) parents should not be rushed through stages of reaction.
5) plans for adequate support should be made before discharge.

DEATH

INFANT DEATH

- newborn is perceived as part of parent, especially mother.
- grieving behavior of parents includes both *classic grieving behaviors* + *behaviors reflecting detachment* (similar to feelings experienced when limb has been amputated).
- as opposed to feelings when spouse or sibling dies, feelings after infant loss are not relieved by identification.
- newborn loss often results in *breakdown in communication between parents* (due to their difficulty in expressing emotions and feelings of guilt, blame).

Supportive actions:

1) parents should be prepared if death is anticipated.
2) parents should be together when they are told of death.
3) every effort should be made to allow parents to hold infant before and after death if they desire to.

   When infant dies without parents having seen or touched him, parents may later feel as though they never really had child - may develop prolonged depression because they could not mourn loss of "real infant".
4) allow time for immediate grieving to pass before discussion of autopsy and burial arrangements.
5) offer support to parents 3-4 months after death (e.g. office visit or contact with parents' group).
6) autopsy reports should be discussed with parents in timely fashion.

DEATH of FAMILY MEMBER or FRIEND

- parents should discuss with health care practitioners whether to have children visit severely ill children or adults (some children may express specific desire to visit dying family members or friends); child should be ***adequately prepared*** for such visit so they will know what to expect.
- 5% children in USA experience death of parent by 15 years of age.
- adults often wonder whether to bring children to funeral; decision should be made individually, in consultation with child (reasonable marker is what child says he or she wants to do).
  - close friend or relative (i.e. emotionally less involved but trusted adult) should accompany child to provide support throughout.
  - child should be allowed to leave if necessary.
  - whereas attending viewing and funeral may aid grieving process of older child, viewing body may be disturbing for young child.

Way child perceives event is affected by child's developmental level:

Preschool children - limited understanding of death (potential apparent indifference); relating event to previous experience with beloved pet may be helpful.

Older children - understand event more easily; death should never be equated with going to sleep and never waking up - child may become fearful of sleeping!!!

Short-term outcome

- young children whose parents die → increased risk for early behavior problems and depression; factors associated with **relatively greater risk** for behavioral and emotional problems:
  1) mother is survivor and sole source of economic support
  2) preexisting, untreated child psychiatric disorder
  3) family history of depression
  4) overall problems of family adjustment to death
  5) previous troubled relationship with dead parent
  6) violent / suicidal death of parent; sudden death (e.g. SAH) per se does not increase risk.

  H: surviving parent, family, schoolteachers, and peers provide support and allow child to resume normal routines.
- adolescents whose parents die → relatively high degree of school dysfunction and depressive symptoms.
- if children experience *prolonged state of mourning* → refer to child psychiatrist or clinical child psychologist.

Long-term outcome

- adult psychiatric literature implicates early parental loss in adult depression.
- multiple previous losses or tragedies, emotionally distant and nonsupportive surviving family → chronic sense of vulnerability to loss.

BIBLIOGRAPHY for ch. "Pediatrics" → follow this LINK >>