

Psychosocial Pediatrics

Last updated: September 5, 2017

CHILD CARE (S. DAY CARE, NURSERY SCHOOL, BABYSITTING)..... 1
FOSTER CARE 1
ADOPTION 1
DIVORCE 2
MALFORMED INFANT..... 2
DEATH..... 2
 INFANT DEATH..... 2
 DEATH OF FAMILY MEMBER OR FRIEND..... 3
PEDIATRIC MORTALITY RATES → see p. Ped11 >>

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 >>](#)