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.

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

- 0-4.5% 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.
- 65% 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 in foster care (50% return within 30 days).
- 15% foster children are adopted.

Types of Foster Arrangement:

<table>
<thead>
<tr>
<th>Type of Foster Home</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended family (kinship care)</td>
<td>Familiarity to child</td>
<td>Risk of similar pathology as parents</td>
</tr>
<tr>
<td>Group homes</td>
<td>Highly specialized for special-needs children</td>
<td>Expense and availability</td>
</tr>
<tr>
<td>Private foster homes</td>
<td>Often highly dedicated</td>
<td>Availability, depends on adequacy of screening</td>
</tr>
</tbody>
</table>

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) 40-70% 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).
  5) increased divorce rate → children are adopted by step-parent spouse of biologic parent who has sole custody.
  6) greater proportion of available adoptees are older, of mixed racial backgrounds, from foreign countries, are high medical/mental or emotional needs.
  7) special health issues exist for these children (mostly infectious diseases - hepatitis B, tuberculosis, pathogenic intestinal parasites).
  8) increasing numbers of older / single adults seek children for adoption.
  9) 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*

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.
**Supportive actions**

- **Stages of parental reaction**

  - **Adolescence**
    - Newborn loss often results in feelings after infant death (e.g. office visit or contact with parents’ hospital).  
    - If death is anticipated, works best when there is cooperation between parents.
    - Adequate support should be made available.

- **Preschool**

  - Regressive behaviors: sleep instability, tantrums, separation resistance, bowel/bladder problems, increased need for attention.

- **Late school-age, early adolescence**

  - Activity directed at parents. Blame and reconciliation about comments about not having done enough to avoid divorce, school and peer problems.

- **Adolescence**

  - Exaggeration of adolescent issues: insecurity, loneliness, social isolation, depression.

- **Patterns of reaction** in divorce settlements:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sole</td>
<td>One parent has exclusive <strong>legal responsibility and physical custody</strong> and some financial support may be ordered by courts.</td>
<td>Loss of emotional contact between parents; less emotional entrapment for child.</td>
<td>Higher risk of not having financial resources for child and custody parent (mother).</td>
<td>Sole custody in mother 75-80% of time; 75% do less well if mother is sole custodian; decreased contact with other parent may lead to long-term emotional problems for child.</td>
</tr>
<tr>
<td>Joint</td>
<td>Both parents share legal responsibility; one parent often has primary physical custody (mother); other parent has more contact than in sole custody.</td>
<td>Less risk of not having financial resources for child and more contact with other parent (father).</td>
<td>More contact between parents; more risk for emotional entrapment of child.</td>
<td>Works best when there is an <strong>amicable</strong> divorce.</td>
</tr>
<tr>
<td>Joint physical</td>
<td>Both parents (in principle) share 50:50 physical custody.</td>
<td>Less risk of financial deterioration continued contact with both parents</td>
<td>Maximal contact between parents; possible disruption of child’s daily or weekly routine.</td>
<td>Requires significant cooperation between parents.</td>
</tr>
</tbody>
</table>

Advice to parents about informing children about 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 >>

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