Questions and Answers

How Should Epidemiological Findings be Applied to Individual Psychotherapy?

Since reading ‘Institutional rearing, parental difficulties and marital support’ (Quinton & Rutter, 1984), and ‘High risk children in young adulthood’ (Werner, 1989), I have tried to apply their findings in individual psychotherapy with children. Three case examples follow:

Case 1
A 13-year-old bipolar adolescent girl, who spent much of her preadolescent years in temporary foster homes, group homes, and hospitals, had a passion for running away, drug use, and finding other unsuitable male contacts who abused her. Citing the ‘Institution study’ finding that she needed someone more stable than she, and needed to delay gratification to achieve, I began pressing her about finding a mentor and a career and staying in one place. Since I was able to follow her through all levels of care and she could call the hospital for advice at anytime, I have had the opportunity to reinforce this message, probably (as she would say) ad nauseum. We got her a volunteer job with a female veterinarian, because she professed an interest in it, but not liking the sight of blood, she decided not to pursue it. She continued her running, not to boys, but to her mother who lived 300 miles away, and who, because of her own illness, was an unstable source of support. She would not stay with her father who lived nearby. The other day she called me from a payphone saying she had moved to another state with her mother, but wanted help to become less tired and to get back on her medication. I agreed to help her in this and again spoke about career goals and schooling.

Case 2
This is a 14-year-old teenager I have followed since he was 6 when his father died. His mother had abandoned him when he was 2. He was placed in a foster home after his father’s death, to which he adapted, but showed no ambition or interest in school. In monthly medication review sessions over the years I have encouraged, even nagged, him to find an interest—a career goal, so he could justify working in school. When he selected marine biology at age 8, I pressed him to get catalogues from a nearby university and to get a mentor in the field. He continued to show little ambition but maintained passing grades in school. His interests shifted to underwater welding. When I discussed his meeting with an underwater welder, he demurred, often making it seem more my career goal than his. Finally, he settled on carpentry … which is the profession of his foster parent.

Case 3
I am working with a child raised for the first few years in an orphanage. Should I discuss with him the finding from the Greek children in long-term residential care study (Vorria, 1998) and encourage him to find a close friend, as confiding relationships appear to be problematic for such children?

References

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Epidemiological Findings:
A Response

This question is an interesting one that requires consideration of several strands of research endeavour and clinical activity in order to answer it because children who are in substitute care have several influences playing upon them. Each of these must be carefully considered if an understanding of a particular child’s difficulties is to be achieved and, more importantly, if the research knowledge is to be correctly applied.

Children such as the questioner describes are no longer with their birth parents, presumably because of the poor and damaging experiences they have had while in their care. The first area of consideration therefore is the quality and experiences that a child has had prior to coming into care. Developmental theorists such as Erikson (1963) have highlighted the crucial part that parents play in the development of a child’s sense of identity and self-worth. The great body of literature that flow from Bowlby’s assertion as to the central role of attachment in a young child’s development (Bowlby, 1951, 1979) adds colour and depth to this understanding. Disruption at this crucial phase creates poor feelings of attachment and, if profound enough, can give rise to an attachment disorder. Empirical work indicates that the quality of life that a child had at this early stage is of great significance, and that a positive sense of attachment prior to family deterioration offers the best prospect of children having fewer difficulties in adulthood (Howe, 1997).

A second strand to the pre-care experiences is the likely level of trauma and abuse that the young infant may have experienced. There is a large body of work in this area which highlights that children who have experienced physical abuse tend to be aggressive and violent in their relationships, while children who have been the victims of sexual abuse will have to overcome distortions of sexual identity and understanding as well as being more prone to substance abuse, depression, and poor social relationships (Beitchman et al., 1992; Egeland, Stoufe, & Erickson, 1983; Leitenberg, Greenwald, & Cado, 1992).

The third strand to consider is that of familial risk. In recent years there has been growing interest in the role that genetics may play in the development of mental illnesses, and links have been suggested for the development of disorders such as alcoholism (Bohman, 1978) and of psychiatric illnesses such as schizophrenia (Tienari, Wynne, & Moring, 1994). The general thrust from these studies is that there is a vulnerability to certain traits and conditions that children can inherit but their expression in any particular individ-
ual also depends upon the environment in which the child has grown up (Rutter & Plomin, 1997). For children who are placed in warm claiming environments these vulnerabilities may be minimised, but for children such as those described in the question, who have experienced multiple care settings, these risk factors will be fully expressed.

The fourth strand of consideration is the impact of being in substitute care. Some of the earlier studies looked at the impact upon children who had grown up in large institutional settings that offered little in the way of emotional support (Spitz, 1945). The findings from such studies reinforce the importance of achieving a sense of attachment in the early years, because when this does not occur there is a gross disturbance of relationships and emotions, a pattern that one set of authors has described as ‘affectionless psychopathy’ (Bender & Yarnell, 1941). Later studies have considered children who have lived in residential settings of a much smaller nature where there has been an attempt to replicate a family-type environment and these have not found such a specific pattern of problems (Pillay, Vawda, & Pollock, 1989) but these children were still at a far greater risk of poor psychological adjustment than their peers and were especially prone to developing conduct disorder (Wolkind & Rutter, 1973).

Long-term foster care has also been shown not to create a strong sense of attachment in children (Adcock, 1980) and it has been proposed that this inhibition is a specific problem of substitute care because the child is unable to establish any enduring secure attachments (Rutter, 1981). Children in such settings often show restless and inattentive behaviour, with tantrums, destructiveness, and stealing being common features (Rowe et al., 1984). It may, of course, be that such difficulties arise because of pre-placement behavioural problems simply continuing and there is a clear association between the level of behavioural difficulties before placement and those shown within it (Borland, O’Harra, & Triseliotis, 1991). These problems are quite likely to lead to disruption of the placement, with as many as 40% of foster placements failing within their first 5 years (Parker, 1966; Trasler, 1960). This is compounded by the fact that the older the child, the greater the potential for such disruption, with the peak occurring around puberty (Brodzinsky, Schechter, & Henig, 1992). Understanding the elements that have contributed to the children’s specific difficulties opens several avenues for therapeutic intervention. A poor attachment experience in infancy and a lack of early positive parenting are profound difficulties for any youngster to overcome. Work with children who show reactive attachment disorder has highlighted the importance of a sustained and committed relationship, with the therapeutic emphasis upon sustained application (James, 1994), as the questioner has clearly pursued in the first case study. In addition, formal therapeutic work that helps the child to establish boundaries, reduce their sense of guilt, and focus upon developing a sense of self-worth can be a very powerful additional element to the intervention (Sgroi, 1982).

A great deal of work exists around helping children overcome abusive experiences, and not least in such an armament is creating a sense of secure attachment within new claiming families (Triseliotis & Russell, 1984). This sense of being claimed by a family that offers positive and consistent care is a potent therapeutic intervention, and underpins the emphasis upon seeking, where appropriate, an adoptive placement for a child rather than a foster setting. The behavioural difficulties that are highlighted in the case examples often make such placements difficult, or may lead quickly to their disruption. Feeling claimed and held may be the child’s heartfelt wish, but their behaviour is focused upon testing such commitments to the point of destruction. An additional pressure upon alternative placements has arisen in recent years as it has become recognised that a sense of origin is important in the process of identity formation (Tizard & Phoenix, 1993; Triseliotis, 1983). This has led to an emphasis upon helping children retain some sense of contact with their birth families. Work done on open adoption suggests that children can cope with the concept of two families (Thoburn, 1994) and for children with no sense of permanence, much of their sense of identity flows from their birth family.

Taken together these results suggest that the therapist should exert every influence to increase the sense of permanence and containment offered by the care setting. The creation of a therapeutic alliance that is enduring, and survives the twists and turns of success and disaster that are so characteristic of these children, is a powerful theme for therapeutic endeavour. Finally, though addressing the impact of abusive experiences is highly desirable, through teenage years it may be that the focus has to be a more modest one of minimising a child’s sense of self-loathing, and helping them to focus on achievable aspirations for the future.

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References


Child Psychology & Psychiatry Review Volume 4, No. 3, 1999