EMOTIONAL PROBLEMS IN CHILDREN

Summary of Round Table Discussion

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As emotional problems in children are closely related to disturbances in parent-child relationships, much of the discussion was focused around this aspect of the topic. Much of the pediatrician's activities with parents concerns itself with attempts to influence parent-child relationships for the benefit of the child patient. A great deal has been learned in child psychiatry about the management of untoward and destructive parental behavior. Much of this knowledge can be used by the pediatrician in his day by day practice. Although, some psychiatric techniques are not applicable in the practice of pediatrics, it is important for the pediatrician to understand his role and not to assume that he is or needs to be a psychiatrist in his attempts at solving difficulties which are presented to him.

Psychiatry has learned some things of what the parent-child relationship shouldn't be. The question might then be raised, "What is a good one?" This can be defined as the capacity in the parent to meet with the child in all matters of day by day living without undue tensions, anxieties or preoccupations. Brennanman has pointed out that about 80% of the practice of pediatrics is in dealing with the parents and one most work through them in an effort to solve the child's problems. There is seldom a situation that involves only the child. It almost always involves the parents and their interaction with the child. Our understanding of many emotional problems has been furthered by our greater knowledge of child behavior and yet we are still too ready to categorize parents and especially mothers with such words as hovering, rejecting, cold, warm, etc., which have little real meaning in terms of understanding how they got that way. Some other useful ways of thinking about parents may be in terms which get somewhat closer to the level of their problems. There are actually many types of parents, at least as they are seen from the pediatrician's point of view. One such type is the "intellectualizing" type. These are people who read everything dealing with child development. They have a planned thought concerning all activities with the child. Most often the planning does not include the individuality of the particular child. Then, there is the "interpreting" type of parent. These are people who make their own diagnoses. Rather than describing the child's cough, they tell the doctor the child has pneumonia. Similarly they may state the child's behavioral difficulty is related to sibling jealousy instead of describing the type of behavior the child displays. This type of parent often evokes hostility in the physician. The "professional" parent is also one known to many pediatricians. This type of parent makes a profession of being a parent. Some of these people are "would-be doctor" variety. Still another is the "mechanical" type of parent, a person who knows all of the rules, who has read all of the books, but seldom really appreciates the child's needs. This type learns that a cry may mean different things, but such parents never learn that a cry may be interpreted readily without having to go through a certain ritual each time to ascertain its cause. Another variety is the "argumentative" or "hypertonic" type. Each point must be argued and the hostility which they have both towards the child and towards the doctor may be very great. There

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is the “anxious” variety. These people worry about all manner of things. They may contact the pediatrician when things are going well to try to find out if indeed things may not be going poorly. There is also the “pseudo-anxious.” They may be worried because they feel it is expected of parents but they really feel little genuine concern. One of the most difficult varieties with which to deal are the “socializing” or “fraternizing” variety. These people would lure the doctor out of his professional role by indicating that as no one really knows an answer to a particular problem, that they would be glad to work the problem out with him. They are often very disarming in this initial approach. A particularly frustrating variety is the “feather-bed” type. It seems that the more one pokes at them, the more they simply fluff-out, such that very little progress is really made with them, nor is there any real impression. The “deferential” parent is a variety with which it is difficult to cope since they will always agree with the physician but then proceed to do as they want. The young physician unintentionally may create another type. This is the “dependent” variety. Initially, it may seem very gratifying to have such a parent who seems to respect so highly the opinions of the physician, but in short order, one realizes that they are unwilling to make any decision without consulting the physician. The “perfectionistic” parent is recognized by being one who desires the child to be a monument to the parents. This may work in both ways—the child who seems to turn out in a desirable fashion but also in the undesirable. The child gains no credit for his successes nor for his failures. The “domineering” variety exercises a great deal of pressure on the child. Frequently they have little awareness of this fact and may make life very difficult for the child. They would mold the child into a preconceived notion. They may also unconsciously wish to live vicariously in the child’s glory. The “self-blaming” type is usually paralyzed into not doing anything. Highly immature people may fall into the “me-versus-the-child” variety. They will frequently tell you that they would not be willing to do anything for the child unless he in turn does something for them. The “doormat” variety is one who seems to be less common today than they once were. This is the variety, seen especially in mothers, who permits everyone to walk over her. She has great difficulty in setting limits for her child and frequently has little life of her own. There is also the “detached” type parent who is remote and removed from the problem. They seem to have little feeling for the child and certainly little desire to acquire any feeling. As the pediatrician gains greater understanding of the genesis of unhealthy parental attitudes, he is able to go beyond these descriptive labels.

PROBLEMS IN FEEDING

With a better knowledge of child development and also a heightened appreciation for the complexities of parent-child interaction, the pediatrician is in a position to understand and advise parents. There are a vast number of situations which require the services of the pediatrician from the standpoint of guidance. One situation that is met constantly by pediatricians is the child, perhaps 2 years old, who is a singularly robust, healthy child, but whose mother nevertheless complains that he will not eat enough. The problem here is not in the child but in the mother’s attitudes and feelings. There are certainly many solutions to any given problem, and always one would have to individualize. One may find that by an increase in the parents’ knowledge of the given problem, they will be quite able subsequently to solve their own difficulty. Attempting to show the mother that the child is quite healthy as based on graphs of the standard height and weight may prove quite useful. Understanding that this child is really normal may relieve her anxiety. Some physicians find that prescribing tonics proves to be useful. This may divert the mother, thereby decreasing the attention on the matter of eating by allowing her nevertheless to be doing something.
Just as this may seem to be useful for some parents one may run into the problem of the child who then will not take the tonic, and the forcing of the child in this direction often has disastrous results.

However, for many parents the attempt to reassure by logic does not appear helpful. One must remain aware that the concerns of parents are frequently irrational. It becomes important to find out what is really troubling the mother, and assist her in recognizing the real source of her concerns which may be about some other aspect of her life, past or present, and not really the child’s appetite. This is an example of the psychological principle of deflection. Too often, we forget that people may be quite able to face the real problem once it is pointed up for them. In reference to feeding problems, most people are noticing a marked decrease in the number throughout the country. This seems related to more relaxed feeding arrangements. Concomitantly, there appears to be little doubt that there is an increase in the number of sleeping problems.

Many pediatricians find that the parent may be reluctant to talk about what is the real problem. They may recognize that the mother is not concerned so much with the robust child not eating but that she is, nevertheless, concerned about something. In an effort to get at this they shift from one problem to another. Pediatricians frequently feel that they in their busy office practice have too little time and inadequate skill to help the parents out. There is always the concern that the problem may be too deep for the pediatrician to handle. Sometimes a solution to this may be that the pediatrician is not sufficiently willing to listen to the problem and is all too ready to give his advice on a particular matter. Perhaps quite unconsciously many physicians may not facilitate their own efforts to get at the real problem since the mother may feel she is being looked upon as the child’s appendage when addressed impersonally as “mother” or her child as “kiddie” and not being called by their proper names. Consequently, the manner of approach becomes very important so that the adage “actions speak louder than words” seems especially appropriate. In the matter of technique it is often helpful not to have the child in your presence. This prevents some parents from opening-up. Although most of the information about a child certainly must be derived from the parent, it is important to remember that a great deal can be obtained from the child and even a very young child. Many times simply giving the mother support in her dilemma helps. One needs to help parents face the reality of their own situation. When the parent can tie in his own problem to the child’s, they may achieve a great deal. Most parents are not, after all, deeply disturbed. The poorly oriented parent frequently can make very rapid change in his handling of a given situation once he faces it. Just as many pediatricians are well aware of the capacity of children to change in both physical and psychological growth and development, one must not forget that many parents have great capacity for change. Consequently, what may seem like very superficial handling of the problem may in fact help a great deal. Sometimes merely evidencing interest in the parent as a person will help to set the stage to getting information.

In general, several steps may be taken to help people arrive at a solution. First of all, one should be interested in them as people. This often sets the scene for allowing them to tell the doctor of their concern about the child and their relationships to him. Secondly, one should accept the concern of parents as real to them even though this is unrealistic and illogical to the physician. An effort must be made to identify the basic, real concern of the parents. There needs to be a constant recognition of the fact that what the parent originally states to be the problem may not in any sense be the real problem. And lastly, by gentle investigation, one probes into the past. Then when these steps have been taken, one needs to allow the parents an opportunity to go to work on their own solution. Since all par-
parents have anxiety with consulting the pediatrician about their child, one needs to help them realize that it is their anxiety and not the child's which is being considered.

In any efforts at counseling it becomes important to realize something of one's own past. Certainly attitudes and feelings that emanate from one's own past ought not to intrude upon the attempts to solve other people's problems. Recently some medical schools are endeavoring to develop an awareness in the students of the problems they themselves may have and which enter into their work with patients but many physicians presently in practice will need to look more critically at this particular point.

Most pediatricians are more likely to think of parents as meaning the mother and often forget that there is a father. In part, this feeling of the unimportance of fathers stems from Freud's classical psychoanalytical dogma which tended to minimize the psychological importance of the father for the child until he was 4 years old or more. As the American cultural pattern is changing, fathers increasingly have more overt concern for the welfare of their children and are more directly involved in their over-all care. So often when fathers are willing and able to come in, a great deal can be learned in the history about the particular problem. Similarly, the matter of advice giving can be facilitated where both parents share in this and can work together on a given problem. In such instances one may anticipate more rapid resolution.

Pediatricians are often in a much better position than the psychiatrist in being able to help people with the many problems confronting them in the rearing of children. When a pediatrician has built up an understanding through his on-going relationship with the family, he is able to point up where the difficulties lie much more rapidly. The psychiatrist must frequently take a great deal of time to develop the rapport which the pediatrician already has. He must also spend a great deal of time accumulating background information before he can proceed.

It is important to realize, therefore, that the pediatrician approaches these problems quite differently than the psychiatrist. It should be pointed out that the psychiatrist is seeing the unusually disturbed patient. Most parents are, after all, trying to help their children. Many times, the job of the pediatrician is to put them back on the right track. At one time, the thinking seemed to be that ignorance or stupidity was the main basis for difficulties in child rearing and that the simple offering of information and the subsequent re-education would solve the problem. Actually, most of the problems in parent-child relationships go back to earlier conflicts in the lives of the parents or to current ones not specifically related to the child. An attempt to get at these may be necessary in order to help the parent with his somewhat disturbed relationship with his child. Some parents can certainly understand and profit by simple explanations. For many, understanding the stages of psychological development is extremely helpful. Many pediatricians fear that by delving into psychological matters, they may go too far and get beyond their depth. By and large this seems highly dubious and perhaps unrealistic. Child psychiatrists perhaps have been overly guilty of protecting the child too much and failing to understand the total pediatric function. A particular problem in practice is one in which one seems to be taking sides or appearing to think only of the child. The parent and his needs are a part of the pediatrician's medical responsibility to the child.

This comes back to the problem of too ready a categorization of the particular parent and the feeling that they are quite unable to change in their manner of approach to a given child. The hypochondriacal parent may transfer his hypochondriasis to the child. In such instances, one needs to help them understand this process. However, one cannot pull out the props of their defense too rapidly.

Although one can recognize that the pediatrician has an important role to play in helping parents understand themselves in relationship to their children, there is still
a group of individuals for whom the more intensive techniques of the psychiatrist are appropriate. A useful yardstick to employ for judging when psychiatric referral is indicated is if the various steps mentioned above have not produced any of the desirable changes after what seems to be a reasonable length of time. In attempting to solve any given problem the pediatrician is helped by knowing the community resources and knowing where he may turn for additional help for his patients. If a parent seems to be regularly misinterpreting your statements, this often gives one an idea of the depth of their disturbance. This may also be an indication for more intensive counseling with the parents possibly on the part of the pediatrician but possibly this is a person for whom psychiatric referral would prove valuable. At the same time, one must keep in mind constantly that the techniques which prove useful with one set of parents may not be at all useful for another.

A special type of situation where parents showed too little concern was considered. A lack of concern may be just as significant as overconcern. This may be due to underlying guilt on the part of the parents. This may be a displacement of the parent’s own unconscious wish to have the child act out in a certain manner. One sees this especially in the denial of parents of slowness in a child who is slightly retarded. They will attempt to hide the fact that the child really is not developing well. The question of whether you should disturb this lack of concern presumably making matters worse is probably overrated. Although, it is true that one should not rush in too fast, there is little likelihood that real danger will be done. However, there are always certain occasions when upsetting the balance in a situation where there are very poor relationships may be quite detrimental. In this instance, the physician is probably well advised not to interfere.

Some members of the group pointed out that it was difficult in a busy practice to find the time for such counseling. The factor of fatigue which comes on late in the day after seeing many patients is also a deterrent to offering sage counsel. Some have solved this by having special evening hours when just counseling is done. This sometimes provides an opportunity for the father to come as well. For some, the problem of whether the parents would pay for this type of counseling seemed paramount. However, many are finding that parents are quite willing to pay for such services.

**DISCIPLINE**

The pediatrician is frequently asked to give his advice concerning matters relating to discipline. This is often a very confusing issue. It may not be clear when the question is asked whether the parents mean actual physical punishment or whether it is a matter of guidance. The words describing discipline are confusing. It also implies training. Recently because of the great concern about the matter of juvenile delinquency, parents feel especially unsure and question their method of handling the child. It is clear that there has been a swing from some of the extreme permissiveness of the era of the twenties and thirties back towards more definite limit setting for children. Yet it is certainly realized that a return to an overly rigid philosophy for child rearing is not what either parents or physicians seem to want. It needs to be pointed out that it is often not what one does, but how one does it that really makes a difference so far as the child is concerned.

Parents nevertheless are worried because of conflicting statements that they read and hear so far as the matter of discipline is concerned. Sometimes the question seems to be “When can I really put my foot down and exercise authority?” Many people seem to be worried about actual spanking. Parents frequently feel very guilty about this and yet it is still a very common procedure. In America today, parents seem to be pretty tolerant of children and their behavior until it exceeds certain limits. These limits vary greatly in different households. In advising parents, one needs to take into account that what may be quite acceptable behavior in one home may be quite unac-
ceptable in another. The parents need to be helped to understand that limits are necessary for the child and that the child actually finds extreme permissiveness not desirable. In an effort to help children with decision making, it is frequently wise to offer “a choice within limits.” One needs to understand the child’s capacity to make a decision at a given time. Psychoanalysis and the John Dewey philosophy of progressive education certainly have helped people in understanding some of the harmful effects of excessive physical punishment. Parents need to understand and to be reassured that an expression of anger, per se, is not bad and that the occasional lapse into more stringent punishment in itself will not be harmful to the child. Above all else, this must be in relation to ordered reality. With the overly strict parent, one needs to help them reduce the amount of their demands on the child. They need to understand how to make reasonable limits. Frequently, by permitting parents to understand that they are too overbearing, they will be able to reduce their demands to the ones which are truly significant.

In discussing any matter of discipline, it is important to consider the age of the child. Consequently with the 2-year-old, action is more useful in securing desired ends than reason which is more appropriate for a 4-year-old. One of the most important things parents need to be helped to understand is that they must have a high degree of flexibility. The adage that one should never give in when some demand has been made upon the child seems quite untenable. One needs to feel secure that a certain amount of direction is important and desirable. In counseling, pediatricians need to help parents to accept this concept and allow them to express their own feelings. People need to be helped to feel that raising children is not such an extraordinarily difficult job and also that the job of being a parent can be pleasant. Many times a return to common sense on the part of the parents will suffice for this dilemma.

Some parents feel very fearful that the show of aggression in a 3- or 4-year-old is a direct road to delinquency later in life. This is certainly not true. In the handling of this matter, it is important to distinguish between authority and the authoritarian approach. The child’s level of dependency will determine the extent of the need for authority. One has to help parents understand the matter of not being too overbearing on the child. Frequently, the matter of what specific punishment is indicated is a very pragmatic affair. For some children being sent to a room is severe and crushing. For another child, this is a perfectly reasonable sort of punishment. One must suit the particular form of punishment to the individual child. In thinking of extremes of punishment, it must be realized that some children develop reaction formations against this. For example, one now sees some parents who as children were raised in the era of extreme permissiveness and now react violently against this for their own children.

**SLEEPING PROBLEMS**

As has been pointed out, there is a rise in the numbers of sleeping problems being seen concomitant with the fall in the number of feeding problems. One of the reasons for this seems to be related to self-regulatory feeding programs for young children. This has been pointed out especially by people like Aldrich. We are accustomed to thinking of the period of around 8 months as being a point of anxiety for many children which seems to stem from the separation anxiety and some sleeping problems are focused on this.

At 5 or 6 months, when sleeping disturbances may be present, the problem is quite different than when it occurs at 2 years. So often, crowded urban living may have a great deal to do with the difficulties at this age. The first born is more prone to have sleeping difficulties than subsequent ones. Here communicated tension to the child is a factor. In an effort at solution of these problems, many physicians are in the habit of using barbiturates in an effort...
to break the cycle. Although this is successful in some instances, many children can resist sleep despite extremely large amounts of the barbiturates. There always is a problem of whether a child should be allowed to “cry it out.” It is not dangerous to call a child’s bluff. Sometimes one episode of letting the child cry it out will suffice.

There is also a period of around 20 to 24 months when again the separation problems seem to take on renewed significance. This period is less appreciated by many than the early one. There are some children who seem to have an especially low frustration level and for them, separation anxiety seems great. In the matter of the separation anxiety it is important to realize that for some parents, in some situations, it is the parents who have trouble separating from the child rather than the reverse. In the matter of sleep disturbances, one can overdo the thought that all sleep disturbances are due to separation anxiety. These children on the self-regulatory feeding program have had little opportunity to understand anything other than immediate gratification. Consequently, the child does not want to give up the mother who is the gratifier of all his needs. The parents must realize that children cannot grow up without any frustration. Even if this were a possibility, it would not be desirable.

For the older child around 2 years, the parents often arrive at a solution of allowing the child to come into bed with them. Many times this does not seem to be too bad a solution. But whether or not this is successful may depend on the parents’ tolerance to having a child come into bed with them. In an effort to help parents who have children with this problem, it is well to point out not to try to change too many things at once. Frequently, parents will be trying to wean the child, toilet train him, solve his sleeping problem all at once. This usually only results in failure. The parent who may display extreme anxiety and anger concerning a sleep disturbance will often frighten the child. This will only heighten the problem and will make it more difficult for the child to go back to sleep. It would seem important to determine if the child is really anxious and needful of the close parental support or if he is using the sleeping situation to coerce and dominate. If this differentiation can be made then the parents’ course of action seems more clearly defined.

In autistic or autistic-like children, there may be a need for physical closeness. In these youngsters, contact with the parents in their bed may be very helpful and should not be discouraged. This is, however, a very particular case and does not apply to the usual type situation.

Concerning the matter of sleeping difficulties or any other problem, there certainly is no single, easy way to the solution. It is always helpful to try to figure out what the need of the child is and an effort should be made to meet this need.

In association with sleep difficulties, there is the matter of night terrors. Night terrors and nightmares are different. One sees night terrors more commonly around age 4 and 5 when presumably there is sexual anxiety due to the resolution of the oedipal conflict. In night terrors the child may scream, appear glassy-eyed, and will have no memory for what caused his fright. For some children, it is helpful to give them a small amount of some carbohydrate at bedtime. Although, this empirically seems to help them in the reduction of night terrors, it cannot be said that these episodes truely represent a hypoglycemic type of reaction. Some night terrors have great similarities to convulsive disorders. These are usually ones which are of long-standing variety and have not just occurred at a particular age.

TOILET TRAINING

On toilet training, children certainly need help with this. This depends on the readiness of the child. It is a readiness not only of the neurophysiological, but the psychological as well. If these factors of readiness are appreciated, toilet training need not be arduous or complicated.
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