THE ROLE OF ADVICE IN CHILD PSYCHIATRY*

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A vast amount of work has been done in the field of chi'd development. There is, however, a distressingly large discrepancy between knowledge available and the u:ilizability of that knowledge by parents to improve the mental health of their children. I wish to discuss some reasons for this discrepancy—for what might be called the 'utilizability gap'.

EMOTIONAL REQUIREMENTS OF CHILDREN

Preventive psychiatry depends on an informed public. All knowledge concerning emotional requirements of growing children implies a practical application of that information. To educate is to advise. Efforts made in this direction have enjoyed very limited success. The limited capacity for utilizing information has made preventive child psychiatry on a large scale a pipe-dream.

Child development is a highly charged emotional field of inquiry. Hardly any information relating to this subject is neutral. The impact of the essential message, conveyed by all the findings, is considerable. The essential message is that, if children are to achieve a creative relationship with their world, a very considerable emotional investment must be made by both parents. There is simply no way of avoiding the work and application required to tune into the communications of infants and children. Parents have to expose themselves to anxieties, hostility, negativism, and the child's need for what appears to be an inexhaustible supply of love and physical closeness. Such ideas are hardly likely to leave us objective and neutral.

All information which goes against the grain of parents' personalities and style of living, will be unutilizable. Information which produces anxiety, for whatever reason, will be experienced as an attack. The implied advice will be felt as persecuting and the informer will be perceived as a persecutor. The more convincing the evidence, the greater will the sense of persecution become. An attitude hostile to the advice is then the probable outcome.

Yet this failure on the part of parents to carry out advice proves to be no real disappointment. Children do not respond to do's and don'ts as such. The cues to which they respond are the underlying attitudes of parents. These attitudes do of course reflect themselves in the nature of the do's and don'ts, but any discrepancy or contradiction between the underlying attitudes of parents, and the adopted and alien attitudes gleaned from advice, will be immediately discerned by the children. Children are just as quick to discern discrepancies and contradictions between the stated and avowed ideals and attitudes of parents, and those ideals and attitudes revealed in their behaviour, opinions, expectations, ambitions, emotional reactions, etc. In the final analysis, children respond to the people in their parents—to the kind of people their parents are.

Clinical investigation reveals repeatedly that where a parent consciously or unconsciously denies the kind of person he or she is, what is denied is perceived by the child. The perception plus the parent's denial produces confusion and exerts a powerful taboo on the child having such knowledge. This not infrequently leads to a generalized inhibition of knowledge and becomes a potent source of learning inhibition and suppression of natural curiosity. Two clinical examples to illustrate this dynamic interplay between parents and their children are offered.

Case 1

A 12-year-old boy was brought on the initiative of his

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parents and against his own wishes, because, unlike his two younger siblings, he was unable to progress at school. He became frustrated at school, hated his teacher, and was observed to lapse into depressed states of which he did not complain and which he actually denied. The parents did not complain of the boy's fearfulness and his generalized lack of adventurousness.

In the initial interview the mother took a good deal of time to impress on me facts which at first sight appeared to be irrelevant, but which proved to be the kernel of the case. She told me of the horrors to which she had been subjected in a concentration camp during the war. She stressed how she had become a fatalist and was unmoved by the children's accidents, hurts, etc. She had never fussed or been overprotective. She had told the children of her camp experiences, and the children were therefore unafraid and not squeamish. The mother presented as a capable woman who did a difficult and important job extremely well.

In the interview with the boy, he was initially uncooperative and offered little or no information. He acknowledged that he was distressed about school difficulties but did not appeal for help. Physically his attitude was cringing and he appeared more afraid than depressed. I finally referred to his mother's concentration camp experiences and asked if he had heard her story. He replied: 'Often'. This hint from the patient was followed by his offering examples of his physical fearfulness.

His own complaint concerned a different area of his experience from that to which his parents drew attention. They complained about his school difficulties and depression. He offered his fear of physical injury. I then inquired about his mother's reactions to hurts, injury, accidents, etc., and went into a detailed history of all such events in the family.

It transpired that his mother—true to her conscious view of herself—did not panic, fuss or become in any way overtly upset. She would instead become momentarily rigid and then continue as though nothing had happened. His mother would also behave like this whenever she became aware that his father was late or whenever the patient asked to go cycling or to spend the afternoon far from home. The effect on the boy was to leave him feeling 'popped like a balloon'. He felt listless and unresponsive 'like a defective'. Yet he had not consciously connected his own reactions 'popped like a balloon' and 'defective' with his perception of his mother's reactions.

Once he became aware of this connection in the interview he could say, 'It's like finding out something you realized you always knew'. In this manner of knowing without knowing he knew he would deal with his mother's denied condition in his interview. This was why he had been unable to appeal for help. Now that he could gain support from my acceptance of this knowledge, he was able to elaborate further. He had come to harbour phantasies of attacking his parents, and his mother in particular. He felt identified with her real persecutors in the camp and the guilt of this was overwhelming. It was now clear that his mother, in the manner of knowing without knowing, had to divert attention from her son's physical apprehensiveness and refer only to his depression about school.

His father and his younger siblings allowed the patient to bear the brunt of the mother's denied problem. The father accepted the mother's image of herself, but this interfered with his ability to accept her as a person. He therefore worked long hours, somewhat needlessly, and his frequently late homecoming contributed to the burden of his wife's fears of accidents and injury.

A further point made clear in this case is that the perception (often referred to as 'unconscious perception') occurs in no magical or extrasensory sort of way. The perception is achieved through the sense organs in the usual way. The subject is not necessarily able to analyse what cues are involved in the transaction and is able to disconnect any emotional reaction from the stimulus.

Case 2

A mother brought her 7-year-old son because he was doing poorly at school. The school report indicated that he was a bright child who was proving to be well-nigh ineducable because of his internal preoccupation. I had heard an account of the difficulties from the mother over the telephone before seeing the patient. I was therefore startled to see a boy with a gross congenital facial deformity.

In my interview with both mother and child, followed by an interview with the child alone, no progress was made. The emotional effect of the case upon me was dominated by the boy's appearance. Would I be introducing my problem if I mentioned it? Was I entering into a collusion with this mother and child, and the school whose report made no reference to the deformity, by denying the impact of this perception? Several pointers suggested the latter. Finally the desultoriness of the interview clinched my feeling that the problem lay with what had not been introduced. I asked mother and child whether we were not avoiding discussing an obvious problem. They could not think of any. I asked pointedly whether there was any difficulty that I could see which had not been mentioned. Again they could not think of any. The denial was now patently obvious. I referred to the unfortunate fact of the boy's congenital deformity. There was no dramatic reaction. Mother said they all accepted it and that apart from some early explanation to the boy it was not talked about at home, and had been accepted as a fact. That it had not been so easily accepted by the child soon became obvious. He surprised his mother by saying that he spent hours secretly examining his face in the mirror. He felt entirely abandoned to contend with his misfortune and his many imagined theories about its cause.

The parents in this case wanted the boy to grow up normally and had been advised 'not to draw attention to it'. They were fearful that he might become depressed over his misfortune. They were unable to see that they feared depression in themselves over this unhappiness. The boy's perception of his parents was of a couple utterly demoralized by him and unable to accept his feelings. He felt dreadfully alone. The burden of his anxiety plus the denial in the family produced confusion and an internal preoccupation with, and about, himself. Once the issue was out and it was felt that I could accept this burden of unhappiness the parents were able to express their phantasies, protests and guilt, etc., about their son.

It must be strikingly obvious that no advice could be utilized by these families. The people concerned simply could not have recognized which piece of advice was relevant to their situation. In this respect these families, though they exhibit unique and unusual features, are typical. Where denials occur, the advice 'don't deny' is useless. The advice 'give children love' is equally useless because the specific love needed by these children was what the parents could not recognize. The specific need of love is different in each instance depending on the unique constellation of factors occurring. The parents who 'didn't draw attention to the problem' chose to behave this way out of their love and concern for their child. They were unable to read his need of love. In this respect they were failing him utterly. Yet they believed they were 'giving love'. In the first example the mother felt she had to conquer her awful experiences of physical terror for the sake of her children. This was her act of love. She was unable to recognize what love meant when translated into the specific need of her child. Parents who administer love in a general way and find no satisfactory result, become filled with despair. They may lose patience and become irritable and punitive. From the viewpoint of the child parental sanctimoniousness ('*we're* giving love aren't we?') will inflame the situation.

There are people in parents. There are people in doctors.[1] The doctor who advised to treat the child as normal, 'don't draw attention to it', believed he was dispensing love. The doctor's advice is often based on the expressions of love and disapproval as practised in his own home. The thesis of this paper is that there is no general principle on which the dispensing of love can be based. Loving has meaning only if it is translated into the practical terms of the love as needed by a particular person, in a unique family constellation, at a given time. The earlier comments relating to the demands on parents and children apply equally well to the demands on doctors of their patients. There is simply no way of avoiding the work and application required on the part of the doctor to tune into the communications of the family in his care. Doctors have to expose themselves to anxieties, hostility and the family's need for what appears to be an inexhaustible supply of love.

Preventive child psychiatry is meaningful only if it offers to clarify the dynamics of family communication. This can be done on a large scale by offering parents the opportunity to meet in groups in a suitable setting. Those people who do not or will not avail themselves of such facilities cannot be reached for practical purposes—but an ever-increasing number of people will consider well-grounded, meaningful and utilizable techniques. Publicity alone is never enough.

SUMMARY

Information and advice to parents for the purpose of preventive child psychiatry has limited value. Two cases are discussed to illustrate the limited use children make of the love and devotion of parents unless their *specific* need of love is recognized. A suggestion is made for an effective approach to preventive child psychiatry.

REFERENCE

1. Balint, M. (1957): *The Doctor, his Patient, and the Illness.* London: Pitman.