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RECOGNITION OF SYMPTOMS IN EMOTIONALLY DISTURBED CHILDREN

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OUR UNDERSTANDING of what's *normal* is more limited than our comprehension of the abnormal because normality has a wide range. What is normal for one individual may not be normal for another. Actually there is nothing in the abnormal which is unrelated to or non-existent in the normal. With the premise that we approach each individual child as a total sentient being — body, mind, intellect, feelings — we recognize that the behavior at any point in his life, 6 or 16 or 60, is a symptomatic expression of the sum total of all he has experienced biologically, emotionally, socially, during his life. *Then* we consider, how does this one child measure up with the average in his whole social group of peers? Does he live, perform, adjust in a reasonably effective, happy, healthy way? *Or is he different?* If different, how different? When can we talk with him, counsel with him, manipulate circumstances or environment which will help modify his difference? When shall we seek the clinical help that is afforded by child guidance clinics in their team approach of psychiatrists, psychiatric social workers, and psychologists? To what should we be alerted? Of what should we be aware if we are to function as preventive agents of poor mental health, mental illness, maladjustment?

There are many categories used to delineate the child who is different. In the report of the 1956 Regional Conference on Physicians and Schools, the section on "Emotional Problems of Elementary School Children" contains a statement that the teacher's role is "to assist in early identification of the school age child showing outward signs of having an emotional problem". Included are the following suggestions for the teacher to use in observing emotional disturbance:

1. Good ability but not producing
2. Reading problems
3. Short attention span
4. Nervous mannerisms
5. Hyperactivity
6. Withdrawal tendencies
7. Aggressiveness
8. Stuttering
9. Crying spells
10. Tiredness

Following are several illustrative but incomplete categories of pupils who show evidence of emotional disturbance:

1. The **hyperactive,** aggressive, "acting-out" child who is the bane of existence in the classroom—the child who can't sit still, can't shut up long enough, pushes here and crowds there, swats, pays no attention, is distractible, short-spanned, and short of control in everything he does.
2. The **withdrawn** child who sits with a faraway look, quiet, shy, living more within himself and his own world than with his peers — the child who doesn't hear when he's spoken to — the child who appears unhappy.
3. The child of very unhappy appearance, who seems **depressed,** not just withdrawn and quiet, who seems nervous, insecure, defeated, abject.
4. The child who seems **fearful,** nervous, who bites his nails — the child who would tell of bad nights and fearsome dreams.
5. The child who has a chip-on-his-shoulder attitude — the child who is **surly, defiant,** quick to take offense — the child who views the teacher, other pupils, and all around him as against him.
6. The child who **doesn't play** or socialize with other children — the child who doesn't appear to be upset or feel neglected — the child who just **doesn't care.**
7. The child who by and large gets along reasonably well, but **erupts explosively,** volcanically, whose temper outbursts are out of all proportion to the stimulus provoking the reaction.
8. The child who seems awkward

and may have trouble reading, writing, or talking.

9. More overt and apt to come to the teacher's attention is the child who is **lying** and/or **stealing**
10. The child whose **sex curiosity** and interest have spilled over in the classroom or playground with stories, words, or open activity.
11. The deliberately **destructive** child — the depredator — the fire-setting, mauling, beating, knifing child.
12. The child who is having serious **difficulty in learning** — the child who has trouble reading or who writes backwards, or who has trouble talking. Is he feeble-minded or is he schizophrenic? Has he an emotional block?

If a child's behavior is symptomatized in any of the above twelve categories *where* should he get help—and *how* should he get it?

Children are *very* flexible. They have wonderful resilience. *Growth* is self-motivated; growth can proceed without much external stimulus and in *spite* of frustrations. As children grow, they test and test and try and try, and each child, in terms of what is inherent plus what is *learned* through experience in living, will respond with his own capacities. In any environment within the framework of a relationship which provides reasonable security, affection, belongingness, consistency, firmness, and steadiness, there is the chance for optimal growth of the personality — for *healthier* minds. Here is where teachers come in as potent forces in the child's life — potent to promote and foster health and happiness, and to help the child already upset, disturbed, warped, to reach the resources that can give him the necessary clinical help. Every time the teacher gives a child a sense of the dignity of his person, a sense of having inherent worth and importance, a sense of having capacities and potentialities no matter how limited, the teacher is providing an experience which contributes to soundness, to health of mind, to happier living.

We too often mention *empathy* as the great boon to fostering mental health and fail to add *strength* and *consistency* - strength to set limitations and structuring — and hold to these so that the child can internalize this sense of strength. Suppose that twenty or fifty *symptoms* are being expressed in the classroom and the overworked, harassed teacher of thirty-six (more or less) children has empathy and feels firm and fair but the child's problem persists. A case study may seem indicated and the child's unmet needs may be pointed up. *When* the child should be referred for clinical help still remains a question.

We should hold in mind this fact — that however important and meaningful the child's relationship with teacher, counselor, nurse, or anyone else in the school environment, a child is most effectively treated and helped through and together with his parents. It is the impasse in the parent-child relationship which must be worked out to set the child free to follow his own drive toward emotional maturity. Of course there are children who, out of their own potential strengths, weather the stresses and strains of disturbed family interrelationships — or parents who are so deeply disturbed and inaccessible that they cannot use help and do not want help. And there are children who react to the immediate situation of family stress and strain (divorce, death, economic deprivation) and express their emotional upsetment in a variety of symptomatic behavior. These children can gain much, very much, through a warm, friendly, understanding relationship, and teachers can help them meet their frustrations and fears, their anxieties and their hurts, by creating an atmosphere of steadiness, consistency, dependability, and *acceptance*. The teacher can be a therapeutic agent by just having an attitude which sets the child free to talk about his worries, disappointments, fears, anxieties. Then the teacher can help the child *use* the positive resources within himself and within his environment.

When the child's behavior is a response to a realistically difficult environment and a troubled and troublesome child-parent relationship, the teacher may be able to help. *But* when the principal conflict does not arise from the immediate present situation, then the child is beyond the reach of talking, counseling, or conferring with him; these techniques cannot help when a conflict is or is becoming an

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internalized one.

Following are three questions which constitute criteria for determining when a child needs clinical or professional help:

1. Is the child's behavior becoming unrealistic?
2. Is the child's behavior becoming repetitive or habitual or sustained or persevering?
3. Is the child's behavior flexible? Does talking over his behavior evoke a difference toward betterment? Does special attention make a difference toward betterment? Does his behavior seem inflexible?

If behavior borders on the unrealistic, if it is repetitive, if it is inflexible, the child and his parents should be helped to reach adequate professional help. And the sooner the better!

There is a very important area in which teachers may be tremendously effective in preventive work — in preventing mental ill health and providing positive mental health. Psychiatry began with working with adults who presented abnormalities. Then psychiatry moved into the area of childhood, of attempting to understand and help the delinquent, the emotionally upset, the mentally sick. Then came the search into what is the *normal* in childhood and the *prevention* of serious

deviation *from* the normal. Now psychiatrists are at the point in development where we are seeking *pathogenic* forces in the family and in the whole community. In older patients or adults there is isolation of pathology from the pathogenic factors. But with the child one *sees* the pathogenic forces operating right in the present, and the intrapsychic process of the child can be perceived more clearly as the dynamic response of a rapidly developing organism that is in a vulnerable state but also a malleable state. The reversibility of deviant reactions can be surprising, and so child psychiatry and associated disciplines have begun to investigate in a systematic manner a new approach to the problems of prevention. The new approach is concerned with the systematic application of insights and skills developed in psychiatric clinics and modified by the contributions of social scientists and epidemiologists. The *purpose* is the identification in the community of specific pathogenic factors and the development of techniques to *remedy* them.

We in child psychiatry have long recognized that we must view the disturbed child as an integral part of his whole emotional environment. We do not focus attention only on the individual child but also on all the pathogenic emotional forces operating in smaller or larger sections of the community. Our aim is to identify these forces and to modify them *before* they lead to emotional illness in the exposed child. Within the family, of course, we know something of the child-mother, child-father relationships and can in a measure describe the disturbances which have a deleterious effect on the development of the child's personality. There are still many unknown forces, and the understanding of multi-body interactions in the whole family is very complex.

In trying to solve the problem of *what* to search for and *how* to recognize pathogenic forces, one concept has proved of value. And here is where teachers may be especially helpful. There are periods of crisis in the affairs of individuals and of groups. The crisis may be a sudden change in social forces, the interruption of emotional bonds, separation, death, divorce, or a period of role transition, such as pregnancy, childbirth, moving from kindergarten to first grade, moving to junior high, or moving to a new neighborhood. We know that individuals and families react to crisis by a period of emotional disequilibrium. In such periods, observation shows *some* maladaptive responses and also a whole range of successful and healthy responses. These times of crisis are strategic points to watch for maladaptive responses that will later lead to disturbed relationships that remain disturbed and lead to emotional disorder. And if we look for *crisis*, there is no better place where awareness of such events may be found than right in the schools.

When we know *what* to look for and *where* to look, the next step is to help these youngsters who show persistent maladaptive responses and then help their parents to accept referral to a specialist. Often there are no anxieties concerning referral to a specialist, but sometimes just to mention going to a psychiatrist will make the parents anxious.

This is the point I wish to emphasize. Crisis comes in the lives of individuals. This time of crisis is of utmost importance. In time of crisis emotional equilibrium in family and individuals is upset. During this disequilibrium changes take place in attitudes and interrelationships that can become stabilized and can affect the entire future emotional health of the people involved. The teacher lives daily with the child in the classroom. The teacher's prompt help may swing the unstable equilibrium toward an adaptive solution or the teacher may refer for clinical help a pupil who does not show the capacity for quick adaptation to the vicissitudes of this crisis event. *The teacher's help at time of crisis is something very powerful as a therapeutic agent for mental health.*

Just a little help from the teacher in times of crisis can go *very far* in helping pupils. By help I mean

Understanding what has happened
Giving emotional support
Relieving anxiety by reassurances

Teachers can make wonderful contributions to the prevention of mental ill health and unhappiness in this anxiety-ridden world. They should feel free to function to the fullest with all their skills as educators.