BEHAVIORAL CONSULT

Kids and Divorce: A Long-Term Commitment

Divorce is so common in the United States – ending about half of all marriages – that it will affect many patients and families in your practice. If your practice has about 2,000 children and adolescents from about 1,500 families, for example, hundreds of families will be dealing with predivorce marital tension, the divorce itself, or postdivorce concerns.

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Start by screening for family functioning at every annual visit. Specifically, try to identify strife and stress early on, at a time when your inventions have the greatest preventive impact. Ask open-ended questions such as, "How are things going in the family?" or "Is there any tension or discord in the family or in the marriage?"

I recommend using the broader term "discord" because it will pick up a pending divorce and also identify other family stressors for the child. For example, research indicates that the years of arguing and fighting that often precede divorce may be more damaging to the child in the long term than the divorce itself.

Once you identify marital or family stress, strive for the following three long-term goals to optimize a healthy outcome for the child.

► First, make sure the child continues to function well in school, with peers, in activities, and in areas of self-esteem. Look for certain key signs that a child is not functioning well. Persistently lower school performance is one. Most children can't concentrate or perform as well at school in the year of the divorce, but it is a warning sign if the problems persist. Determine whether the child is still having difficulty adjusting to the divorce, and assess if there is ongoing discord or fighting about visitation, custody, child rearing, or finances after the divorce. Another warning sign is the child who drops an after-school activity during a divorce crisis, and fails to resume it the next school year.

How a child relates to friends after the divorce can be important. In particular, ascertain how young or midadolescents treat members of the opposite sex. Look for patterns in their relationships that repeat some of the dysfunctional behaviors of their parents' marriage. Keep in mind that children are often unaware that they are repeating these family patterns.

For example, are girls who are adversely affected by divorce especially vulnerable to getting involved with older teenagers who might take advantage of them? Do you see any evidence of longing in the girls, or signs that they are seeking to replace something missing in their paternal relationship? This type of behavior is much less likely if the girl has had a good relationship with her father before, during, and after the divorce.

With teenage boys, consider how they treat their girlfriends. Is the boy supportive in his relationships, or does he have girlfriend after girlfriend because of a callous or insensitive attitude?

Referral for a mental health evaluation might be appropriate if you see a pattern of continuing dysfunction in a major area of the child's life or of unsatisfactory relationships as these younger teenagers enter high school, particularly if they are alienated from a parent.

► Second, ensure that parents are open and willing to answer the child's questions as the child tries to make sense of the divorce at each developmental stage. Help postdivorce families encourage the child to ask questions on an ongoing basis. If divorce happened when the child was a toddler, for example, they are going to have questions 5, 10, and 15 years later that they could not conceptualize until they reached the appropriate developmental point.

Parents may need your advice on how best to talk to their 5- or 8-year-old, a time when information should be concrete and straightforward. In contrast, a 14-year-old may be able to understand more conceptual and nuanced answers to their questions. For example, a younger child is unlikely to think about the divorce in terms of an extramarital affair or the impact on their college finances, but that may not be the case when the child is 14 or 15 years old. Keep in mind that many adolescents do not ask parents such difficult questions unless they are given permission in advance, and it's at a time when they feel safe and at ease.

► Third, counsel the family to facilitate a good relationship between the child and each parent over the long term. When families come to me and there is a lot of tension about visitation, custody, and money, I often focus them on the long-term goals. I ask, "What kind of relationship do you want with your child 10 and 15 years from now?"; "What is likely to result in a good long-term relationship with them?"; "Do you want to be able to be at their wedding?"; "Do you want to be close to your grandchildren?" Going all out for an extra few hours of visitation or not paying a bill is not likely to help achieve these long-term goals.

Again, early screening and intervention make your job easier. If a patient or family comes to you after years of negativity and a court fight over a bitter divorce, your ability to intervene effectively is already very limited.

Divorce is often an angry and divisive time. You can advise parents not to act out of anger by offering examples of divorcing parents who invested a lot of time and energy into winning short-term victories, only to see their efforts backfire later. Some parents believe that the child will be closer to them if they can make the child angry at the spouse. But children who feel they have to betray one parent to please the other often become resentful of this role over time.

In contrast, children who observe their parents working together with a sense of harmony and cooperation to make the custody, visitation, financial, and other arrangements successful are much less likely to blame themselves for the divorce. They also are much less likely to feel guilty when they connect more to one parent or the other at different points in their development.

It is important to monitor your patients for long-term effects of divorce up to and including the time you transition them to an adult care provider. Ask the older adolescent questions such as, "How do you feel about the divorce now, looking back on it [5, 10, or 15] years later?"; "How do you think it's affected you?"; and "Are there any things you'd like to change?"

If you do a review of how they integrated the divorce when they are in 10th or 11th grade, you will still have time to address any unresolved issues. If the child is distant with one parent, you can at least wonder if this is a point in time to reconnect and repair that relationship before the teenager goes to work or college and moves to being fully independent.

Pediatricians often have limited time to intervene. Some find this work very gratifying and feel comfortable with divorce-related issues. Others may choose to refer the patient to a social worker, psychologist, or child and adolescent psychiatrist, according to the severity of the situation. Some pediatric practices are fortunate to have a full- or part-time social worker.

If you want to counsel but your time is limited, consider offering a divorced-parent discussion and education group in your practice. You and/or a social worker could facilitate this forum. This resource can help parents share their experiences and strategies to ensure that children emerge as happy and healthy as possible after a divorce. In addition, this intervention can be cost-neutral if you charge parents a nominal fee. ■

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ADHD Less Prevalent 6 Months After Adenotonsillectomy

BY BRUCE JANCIN

FROM THE ANNUAL MEETING OF THE ASSOCIATED PROFESSIONAL SLEEP SOCIETIES

SAN ANTONIO – Many children with attention-deficit/hyperactivity disorder or oppositional defiant disorder no longer meet diagnostic criteria for these psychopathologies 6 months after they undergo adenotonsillectomy for standard indications, a study suggests.

The most striking finding in a large prospective patient series study of 140 children aged 3-12 years who underwent adenotonsillectomy involved the 81% reduction in the prevalence of oppositional defiant disorder (ODD) at 6 months post surgery, Dr. James E. Dillon reported.

Baseline rates of ADHD and ODD were high, in accord with earlier studies of children scheduled for adenotonsillectomy: 54 (39%) met DSM-IV criteria for some form of ADHD; and 26 (19%) met ODD criteria.

At 6 months after adenotonsillectomy, however, only 32 patients (23%) still met criteria for some form of ADHD. The rest no longer did. Particularly impressive was the reduction in ADHD of the combined type: Overall, 30 kids (21%) met the diagnostic criteria for this disorder at baseline, compared with 18 (13%) at follow-up, said Dr. Dillon, a child and adolescent psychiatrist at the University of Michigan, Ann Arbor.

The prevalence of ODD dropped from 26 children at baseline to just 5 (3.6%) at 6 months post surgery.

The participants were recruited from various otolaryngology practices in Washtenaw County, Mich. Before being approached for the study, all of the children were already scheduled for adenotonsillectomy, generally for indications including sleep-disordered breathing. The subjects' mean age was 7.2 years, 55% were boys, and 78% of the children were white.

Psychiatric diagnoses were made by a child psychiatrist, developmental pediatrician, or child psychologist based upon findings on the computerized National Institute of Mental Health Diagnostic Interview Schedule for Children Version IV, coupled with additional relevant history and direct observation of the children.

The study population included 35 preschoolers. They had somewhat higher baseline rates of behavior disorders than did the older children, but their pattern of psychopathology and the response to surgery were similar to that of the older children.

Specifically, 19 preschoolers (54%) had a behavior disorder at baseline, compared with 12 (34%) at follow-up. In all, 9 preschoolers met criteria for ODD at enrollment, compared with just 2 at the 6-month follow-up, and 19 had any form of ADHD at entry, as did 12 at follow-up.

Dr. Dillon reported no financial conflicts with regard to the study. ■