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Severe School Phobia*

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The setting is a kindergarten in the basement of a church several years ago. Mothers are bringing their children who, for the first time, will be away from home several hours a day. Reactions differ, but all the mothers are a little anxious and so are the children.

Jerry did not want to stay and when his mother started to leave he ran to her, an expression of fear on his face; he grasped her hand and would not let go. She remained in the back of the classroom that morning, and soon Jerry was participating in the activities. The next day he was a little more relaxed, but wanted to leave when his mother started to leave. As long as she remained in the room Jerry was fine, but he watched with a "peeled" eye.

This kindergarten started the children in conversational French, and the enthusiasm of the teacher soon involved all of the children in repeating after her in French the names of various objects in the room: la porte, la plume, le crayon, etc. On the third day of nursery school the teacher introduced the word Madame. The children repeated in chorus—MA-DAME, MA-DAME. They were all absorbed.

A small hand shot up in the front of the room and a boy's voice said, "Teacher, teacher, my mama says God-damn. He repeated, "Madame, God-damn."

Jerry's mother no longer sat in the back of the room. She was on her feet, out of the room, in her car, and on the way home. Jerry did not notice that she had gone until later and the teacher reassured him with relative ease. Jerry's mother said later, "I figured if he could say that he could stay in school without me."

There was no further trouble in separating from Jerry, and he has gone to school quite happily ever after.

At the beginning of any school year in thousands of classrooms around the country, some variation of this theme is repeated. The mutual anxiety surrounding

the separation of mother and young child is probably, to some extent, a universal phenomenon. Fortunately, for most children it is mild in nature and short-lived. Being able to tolerate the anxiety surrounding these early, temporary separations, soon represents a giant step forward on the long road of individuation which must be traveled if the child is to succeed in becoming a person in his own right.

That the term "school phobia" is inaccurate is generally agreed. None of these children whose pattern of occasional, irregular or non-attendance at school (which we call school phobia) have a fear of school as the primary concern. They are all anxious, but the basic anxiety is concerned with the child-mother relationship; hence, when this relationship is threatened, the separation anxiety surfaces and is expressed in the child's inability to reach or remain in school. Children with this pattern of behavior are to be distinguished from those with truant or running away behavior. The clue to the school phobic child is his continual physical-emotional proximity to his mother and the anxiety that ensues when this closeness is threatened. The truant or run-away may be anxious about many things—a bully at school, inability to achieve up to parental expectations, fear of failure at sports, discord at home, or poor motivation. The difference is that this child can separate from mother.

Where are the origins of this prevalent problem? Its roots are to be found in the periods of development prior to school age—at a time when partial failure to master early psychological development leaves the child vulnerable. The child with any marked degree of school phobia may be viewed as a child who has not progressed satisfactorily in his development of autonomy. He is generally a child with a high level of ambivalent feelings regarding compliance and non-compliance, affection and anger. To a great extent this child has progressed through this early stage of mastery in such a tenuous manner that he has large remnants of insecurity woven into his fabric. Such a child has unusual difficulty in establishing clear, comfortable relationships with father and mother. He

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has difficulty finding out where he fits into the family picture. In other words, the poorly resolved conflicts at these early stages of development hinder the child from continuing his development of autonomy—that he might have an ever increasing sense of his own identity as an individual. Almost invariably it is this kind of insecure pre-school development which the school phobic child has as his psychological heritage.

This problem develops in the early relationships of the family. Mothers of school phobics are usually emotionally insecure individuals themselves who have marked dependency needs that have not been met. They have a common history of unhealthy dependency relationships with their own mothers which never have been resolved. They perpetuate this dependency with their own offspring through spoken words, the way the child is held, the limitation to explore that is imposed, and an overall attitude of restriction of freedom. These are a few of the many channels of communication open to the mother, and the dominant emotional message that she sends to the young child is that she needs him with her. This starts early and soon a symbiotic relationship exists.

What about the fathers in this family problem? Though it may be expressed in a number of ways, the fathers generally conform to a pattern which accentuates the problem. Predominately there is a history of being linked to an over-solicitous, dominating mother who had difficulty allowing her son the freedom to be. Usually the fathers of the phobic child are described as “being away” from the family, either physically or psychologically. It would often appear that they have chosen marriage partners with many of the same personality characteristics as their own mothers. Then, in order to escape the self-made trap, they have functioned on the periphery of their own family. Occasionally the father's own unmet dependency needs are expressed as a competitiveness with his wife in an over-protectiveness of the phobic child.

The attendance pattern of school phobias is varied. Attendance may be irregular, or not at all. They may refuse to go on Mondays. Refusal may come after some illness either in the child or a member of the family, after a move or a transfer to a new school, or when a new baby is in the family. It can be almost anything which upsets the delicate balance of the child's adjustment and with which his brittle ego cannot cope.

There are many related signs in the severe school phobic. He may be afraid to go other places. Enuresis is common. Frightening dreams and sleepwalking are common. There is the fear that he will die, or that parents or siblings will die. Many of these children are withdrawn and depressed; the older ones may express suicidal threats or make actual attempts. Somatic complaints are commonplace—stomach aches, headaches, vomiting, anorexia, dizziness, diarrhea, and sometimes asthma.

By the time the symptoms are full-blown the picture is extremely complicated. The entire life of the family may revolve around the phobic child. Frequently one hears, “This child controls the whole household.” The total stance of the child is to prevent the separation from mother and to avoid the accompanying anxiety and panic that follows. He often accomplishes this in adroit ways—through promises, threats, denial that there is a problem, projection of all causes onto the external world, and many others.

None of the principals (child, mother or father) of course recognize the basic factors involved in the phobia. Thus so the charged relationships continue, the heat of the mutual anxieties feeding each other, and matters do not improve; they often get worse.

Most clinicians who have investigated and studied school phobias view it as a psychoneurotic reaction, based on unconscious conflicts. Many reasons are given by the child and family for the refusal to go to school; but these reasons are rationalizations, and the true reasons are unknown to them. This is an all-important point for anyone to know and remember who is trying to deal with a school phobic child, but it is often overlooked by physicians, school personnel, and sometimes psychiatrists. There is danger in trying to handle by common sense a child whose anger and rage and ability to control others is obvious, a mother whose ambivalence tells a child in words to go to school and who at the same time communicates her anxiety if he does, and a father who is often emotionally unable to help. “Common sense” may take the form of reassurance, physically dragging the child to school, repeated whippings, bribery and threats of all kinds. It may be possible to return a child to school with such methods, but the problem is hardly ever solved, particularly in the severe cases. Inside, the child is panic stricken and doesn't know why; the anxiety is so great that he disorganizes and can do nothing. This is hardly an ideal situation under which to pursue knowledge. Treatment must be aimed at relieving the underlying conflict in the child and helping the parents, particularly the mother, to understand their part in the matter.

Treatment plans may take many forms and depend on many factors: age of the child, time of onset, circumstances under which the refusal begins to develop, whether it is sudden or gradual in developing and amount of awareness of the parents.

For children like Jerry, professional help is not needed. However, if the refusal is frequent or persists for any length of time, not only a pediatric examination is called for, but a psychiatric evaluation as well. The latter is to include the child, mother and father. It is a family problem. Most of these cases can be handled on an out-patient basis, the mild ones often in a very short time. Others take considerably longer.

Severe School Phobia

Over the past seven years 35 difficult cases have been treated as in-patients at the Virginia Treatment Center for Children. Their ages have ranged from eight years to 15 years, with the vast majority falling in the 11–12–13 year age group; boys and girls were about equal in number. This group of children has proven very refractory to any attempt to help. Overt symptoms have been present from several months to several years, and school attendance patterns varied at the time of admission from an occasional day to complete refusal. Several of these children had been out of school for a year or longer. The most common pattern was a dragging on of symptoms, with complete refusal coming as the child moved into puberty. In several instances a move, change of school or illness had been the most obvious factor precipitating complete refusal.

All of these children had a long history of many somatic complaints and all were extremely anxious. As a group they had a pervading, low self-esteem. Their behavior was immature, and most were extremely afraid to express aggression, though their controlled simmering anger was obvious to the casual observer. Practically all of them were average to superior in intelligence, but most were behind academically.

In each case the child and mother were linked in a mutually hostile-dependent relationship. Most mothers were characterized as dominating and over-protective, while fathers were characterized as rather passive and usually having little meaningful association with the child. All had undergone various attempts at treatment by family physicians, local mental health clinics, psychiatrists, psychologists or many combinations thereof. Duration of treatment was for months to years and often intermittent in nature. Too often coercion and bribery had been used to get a child back to school, but ultimately it had been 100 percent ineffective.

Pre-admission plans at the Virginia Treatment Center for Children were as follows:

- 1) Child and parents were brought to the out-patient clinic for psychiatric evaluation.
- 2) If the picture was clear, an interpretation was made to parents and child (sometimes all three together). The seriousness of the problem was pointed out and it was emphasized that it was a family problem with in-patient treatment needed. The family was told that change was unlikely without intensive treatment and, though often they did not like it, this they could understand in view of the many efforts that had been made already without sufficient change.
- 3) Parents and child were told to return home and think about the matter for a week and to let us hear from them. If they wished, we could then set a prompt

admission date. Before leaving they were given a tour of the Center, including children's living units, and were introduced to several staff and children. Referral sources were notified of our findings and recommendations, and often were of great help in supporting the idea of admission. If we did not hear, family was reached by telephone and asked to come back for further discussion. Only a few cases did not follow through with admission, but each was filled with hesitations, starts and stops, reflecting great anxiety.

On the date of admission parents and child could be seen moving with slow, measured steps from the parking lot, the child and mother usually holding to each other. Parents were permitted to go with child to the living unit and separate there; often they wished to "get it over with as quickly as possible" and preferred not to go to the unit. In either case mother and child (and sometimes father) flooded the floor with tears, and the child had to be separated physically from mother. This was done decisively, and parents usually left at once. Younger children usually publicly cried and wailed, while older ones preferred to be alone to cry.

However devastated the child appeared to be immediately after the separation (and this was the rule) he frequently began to pull himself together within the hour. No one chastised him for crying and no one "babied" him, but nursing staff was always nearby and available. Other children became curious and asked the child questions. Pretty soon he would be drawn half-heartedly into some activity, and the uncontrolled crying and sobbing ceased. It recurred at times often for a week or two but with a diminishing intensity.

Although not permitted a visit home for at least two weeks after admission, short visits were arranged at the Center if parents became too anxious. Letter exchanges and occasional telephone calls from child to parents were encouraged. Parents were seen in the out-patient department once a week if possible, and often twice weekly in the beginning. They would drive for great distances to keep appointments, and in a few instances distance was so great and circumstances such that parents could seldom visit. Local public health nurses made home visits each week and a member of the VTCC Field Unit made a home visit from time to time.

In his day-to-day functioning the child's progress was often amazing. With rare exception they were involved in the intra-mural school program within three days and attendance was no problem. It was characteristic that these children were often "picked on" by other children and sought protection from staff. This was given to prevent a child from being hurt by another, but the phobic child was continually reminded that he had to learn to fend for himself. Remember that he had had little practice at this.

All children were seen in individual psychotherapy one to five times a week with the aim of helping each child discover the sources of his ambivalent feelings and his tactics of evasion and avoidance. A therapeutic daily program was tailored for each child, aimed at helping him succeed in the different areas of living, to foster a developing independence, and to function as a part of a group. For instance, many times arrangements were made for a child to travel home by bus, sometimes for long distances. Many similar practices were directed toward building in the child the knowledge that he could do things for himself, causing his inventory of accomplishments to increase quite rapidly.

Treatment can be quite stormy and trying for staff, for these children with their great ambivalence have an expertise in manipulation of adults, with the result that they create animosity. In the therapeutic endeavor, considerable attention must be directed toward helping child-caring staff understand the child's behavior to avoid their reacting with counter hostility to the child's reservoir of anger. This would only recreate the unhealthy situation from which the child came.

The 35 children in this study stayed in residence at the Center on an average between four and five months, and a few stayed a year—the maximum allowable by law in this children's psychiatric hospital. The shortest stay was three weeks, with the child being taken out against medical advice.

Of the 35 children, 28 were considered to be successful. The measure of this was that on return home: they went back to school, the related symptoms diminished markedly or disappeared, and they were much happier children who did not have to spend all their time and energy in defending against separation anxiety. This is not to say that these children have no problems, but at least they are not major ones and the children have been able to go on in a productive healthier adaptation. At this time follow-up information covers several years to a few months, and the more recent cases will be followed for several years.

The seven cases that were considered unsuccessful deserve brief comment. All of these children made considerable school progress while in the hospital. All increased their self-esteem, and all showed a diminution in related symptoms.

Five of these children were adolescents. Each of these seven children came from extremely disturbed and chaotic families with whom our staff thought we had been unable to effect any change in basic attitudes.

One of the girls did not return to school and was married promptly. Another adolescent girl returned to school, but continued to have many other problems. A third much improved girl soon refused school, and her mother would not return her for readmission.

One adolescent boy made much progress in all areas, but when he returned to his home where his father was an emotional invalid and his mother a near invalid, he did not go back to school. No follow-up was possible on a fourth adolescent girl, but it is doubtful that she returned to school. A pre-adolescent girl was removed against advice and did not return to school. A pre-adolescent boy, although markedly improved here, continued very erratic attendance at school.

In each of these seven cases staff was of the opinion, even during the diagnostic phase, that the possibility of the child's returning home and living a fairly normal life was extremely unlikely. None of these parents could entertain the idea of the child going somewhere else to live. Apparently our efforts were too late and too little in the face of odds that were too great.

The Advantages of In-Patient Treatment

Our thoughts about the in-patient treatment of severe school phobias, on which little information has been reported, is as follows:

1) Though separation of parent and child in a situation in which both panic at the thought appears to be a drastic move, it may be the last heroic effort that can be made to solve the conflicts and return a child to school. The longer a child is out of school despite all therapeutic efforts, the less likely he is to return. He continues to fall behind academically and this becomes a deterrent to his returning.

2) If admission does occur, staff must be geared to an all out effort to deal with the pinnacle of anxiety and panic that is likely to occur in mother and child. This is often easier to deal with in the child than the parents. Caseworker and child psychiatrist must be available for impromptu appointments and telephone calls from anxious parents. After the initial phase, parents and child learn that, even though uncomfortable, each can survive on his own. Children handle this with greater facility than parents. For both this holds a promise for their future.

3) The separation often gives all concerned a chance to breathe, to sort out their conflicting emotions, and many parents become highly motivated to find a better way to live with the child. Often mother and child have become physically and emotionally exhausted in their day-to-day struggle with their hostile-dependent relationship. Frequently parents discover a new relationship between themselves that has been absent or dormant for years; they find time for an interest in each other.

4) The child finds himself in an environment with certain expectations that he can stand up for his rights. He is thrown into close relationship with other children where he cannot be omnipotent, and he begins to learn how to cope with group living. He is in a

living situation where his assets are recognized and where adults express trust in him. He begins to trust himself. Though the child may protest admission, and scream "bloody murder," he actually appears to be relieved that someone has intervened and to an extent taken the power away from him. This would make good sense in light of frequent comments in the psychoanalytic literature that this child is terrified of his seeming omnipotence and magical thinking which he has carried over from early childhood.

5) He is back in school and achieving, and at some level of awareness this must demonstrate to him that school is not the main problem. It makes it easier for him to make sense out of his defensive maneuvering. He sees other children with problems, some with school phobia, and he sees children return for visits who have largely solved their problems. He becomes curious about these other children and sees some hope for solving his problems.

Summary

This presentation has emphasized that the underlying conflict in school phobias begins as a bilateral separation anxiety between mother and young child. This unhealthy symbiotic relationship, occurring during the time that the child is trying to develop his own autonomy, cripples his ability to cope with the separation anxiety when he goes to school, or in the face of certain life events such as a move, illness, or birth of a sibling which revive this early anxiety. The response is a disturbed pattern of school attendance which may range from mild to severe and acute to chronic. These basic conflicts represent a neurotic reaction of which child and mother are not aware.

General information has been presented about 35 cases of severe school phobias treated at the Virginia Treatment Center during the past seven years. Twenty-eight of these cases have been successful and seven are regarded as unsuccessful. From this experience it is our impression that in-patient treatment for severe school phobias should be tried, rather than a continuance in a variety of other efforts at treatment which have been ineffective. The longer these conflicts continue without effective treatment, the further the child falls behind and the chances of his successful return to school lessen.

We have emphasized the importance of early psychiatric diagnosis and treatment once a school phobic pattern evolves and have highlighted the difficulties and vicissitudes surrounding treatment of the severe school phobic child.

Unfortunately, not all children have the healthy base that Jerry had for handling his early school anxiety. Many children reach the severe proportions described previously. Even so, this study demonstrates that many severe school phobias can have a reasonably successful outcome.

Special Characteristics of Adopted Children and Adoptive Parents as Seen in a Psychiatric Practice*

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Introduction

Adoption and the adjustment and emotional development of adopted children have been of continuing interest to those in the psychiatric field for some time (Lawton and Gross, 1964). Many studies and reports reflect an apparently high incidence of adopted children being referred for psychiatric study and treatment (Schechter, 1960; Toussieng, 1962; Goodman, Silberstein and Mandell, 1963). There is almost as voluminous a literature criticizing the statistical analyses and conclusions of these papers, though the titles do not always suggest that this is a major element in the discussion (Kirk, Jonassohn and Fish, 1966; Reece and Levin, 1968; Offord, Aponte and Cross, 1969).

A number of articles deal with presenting symptomatology in an attempt to explore some distinct personality adaptation that would characterize the adopted child and his problem (Offord, Aponte and Cross, 1969; Borgotta and Fanschel, 1965). Other papers discuss the psychodynamics they feel to be characteristic of the adopted child (Lawton and Gross, 1964; Schechter, et al, 1964; Wolff, 1969; Schechter, 1967). In addition to articles in medical journals and textbooks, books and monographs dealing specifically with adoption and its impact have been written, chiefly to reassure those in adoption work and agencies that their work is useful and effective (McWhinnie, 1967; Kellmer-Pringle, 1967; Kadushin, 1967; Illingsworth, 1969).

The purpose of this paper is to present our experience with adopted children in a private child psychiatric practice over a 42 month period. Recognizing that there are many selective factors such as economic status, sociocultural attitudes and levels of education affecting the pattern of families seeking private psychiatric care, we hope that our experience will be of interest and of value. Our report comes ten years after that of Dr. Schechter (1960) which provoked so many subsequent studies and discussions. We have found one other reference to experience with adopted children in a private practice (Jameson, 1967) as distinguished from a psychiatric hospital or outpatient psychiatric clinic experience with extrafamilial adoptions.

Practice Setting

Ours is a private practice limited to children and adolescents, involving the "team approach." An evaluation almost invariably consists of an interview with both parents, in which an extensive statement of the problem is elicited with both the psychiatrist and the psychiatric social worker present. The parents present and describe the symptoms in their own terms. Critical areas in the child's development such as toilet training and entrance into school are also covered. The child is undergoing psychological testing while the parent or parents are being seen. The usual battery of tests includes the WISC (or WAIS when indicated), Rorschach, Bender-Gestalt and/or Kendall-Graham, D.A.P., T.A.T. and, in the case of adolescents, a Sentence Completion Test. The child is then seen by the psychiatrist for a 50 minute session either in the playroom or in the office as determined by the child's age and/or choice.

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ADOPTED CHILDREN AND ADOPTIVE PARENTS

The parents give the psychiatric social worker a detailed history of the child's early growth and development, medical history, habits and responses to training and schooling. In addition, the psychiatric social worker focuses on the marital history, family interactions and relationships, and the nature and personality characteristics of the parents and siblings. When possible, time permitting, the early histories of both parents are obtained as well.

There is then a staff conference to determine the degree and nature of the problem and develop a treatment or referral plan. The parents return for an interpretive interview. This is usually a joint effort of the psychiatrist and the psychiatric social worker (Saunders and Lindemann, 1966) or, as in some instances, involves all three members of the team. It has been our usual procedure to offer an interpretive interview to patients at the adolescent level and, in most instances, they avail themselves of the opportunity.

In 42 months, a total of 281 children and their families underwent total evaluations. In that same period, 128 children and/or their families were entered into treatment. Of the total number evaluated, 34 children were extrafamilial adoptions. This figure represents 12 percent of all evaluations. Of these 34 adopted children, 22 entered into therapy with us. This represents 17.2 percent of our treatment cases. Of the remaining 12, we know of four who went into treatment elsewhere upon our recommendation or referral. This compares closely to the figures presented by Schechter in his 1960 paper and Jameson in a 1966 report. We were struck, as they were, by this apparently high proportion of adopted children, and it led us to study the nature and characteristics of our cases. Of the 22 cases there were two families who presented two adopted children for treatment. Thus, we studied 22 children and 20 sets of parents; 12 children were prepubertal, six in early puberty and four in mid-to-late adolescence. There were 12 males and ten females. Nine had been adopted prior to three months of age; six between three months and one year and five had been adopted after the first year but prior to the third year of life. The two remaining cases were adopted between the fourth and sixth year of life.

Nine of the 22 cases were the first child of the family, ten were second children, and one was a third child and was adopted after the age of four years. There were two "only" children.

In two families, the adopted child was preceded by a natural child. In four families, natural children were born to the family following the adoption of the patient.

Psychological Test Findings

Psychological testing indicated that four children

functioned in the superior range, six in the bright normal range, ten in the average range and two at the dull level. Both children at the dull level were also showing signs of minimal brain dysfunction. One child in the average range showed evidence of brain damage which was known to be related to trauma from a head injury. With the exception of five cases (two average, two dull and one bright child) all the patients reflected a higher potential than the range at which they were operating. Anxiety was felt to be the factor that was affecting their intellectual function.

Presenting symptoms, as offered by the parents, have been of concern to authors on this subject (Offord, Aponte and Cross, 1969; Borgotta and Fanschel, 1965; Wolff, 1969). There is frequent reference in the literature to overt aggression, sexual acting out and other forms of antisocial behavior, though Schechter in his 1960 paper stated that the symptoms were nonspecific when compared with those of non-adopted children receiving psychiatric attention. We are in agreement with Schechter.

Problems Noted

In our series, the predominant problem being expressed by the parents was underachieving in school, mentioned as a primary symptom in 12 cases; or school behavior problems, mentioned as the primary symptom in seven cases. Frequently, psychiatric referral had been recommended or demanded by the school system—public, parochial or private. Other symptoms mentioned ranged from overt "school phobic" behavior to suicidal threats, impulsiveness, immature behavior or lying and stealing. In only one case was bizarre behavior presented as the complaint and this child was found to be quite clearly brain damaged. In no instance was any psychopathic or truly delinquent behavior reported.

Diagnostic Categories

Psychiatric diagnostic categories seemed to fall into clusters also. There were 11 cases that showed marked anxiety neuroses. Four fell into the personality trait disturbance category. The behavior of three children placed them in the unsocialized aggressive reactions of childhood classification, and two were clearly brain damaged as a major diagnostic finding. The validity of diagnostic categories is frequently challenged, especially when working with emotionally disturbed children. It has been our experience that we wish to find the most descriptive but the least noxious terminology with reference to future stigmatization of the young patients; therefore, diagnostic nomenclature rarely gives a true picture of the psychodynamics within any particular given child. We did not feel that our adopted patients were more emotion-

ally ill or differed significantly in presenting symptomatology than a control group of patients matched as closely as possible for sex, age and family constellation.

Anxiety Trigger

It was of interest to us that the symptoms were related to anxiety. The anxiety was pervasive and gradual in onset. There was frequently a trigger situation which increased the anxiety to the symptom producing level. This was most frequently an environmental change such as entrance into school, changing schools as from grade school to junior high or going away to boarding school, a family change of residence, or the introduction of a new sibling altering the family constellation and balance. In some instances, a clear-cut traumatic episode such as a sexual incident, bodily injury or a death in the primary family unit was the traumatic factor.

The chief source of anxiety was abandonment fears, frequently reflected as unconsciously determined *separation anxiety*. These fears were present in 19 of the 22 cases. They were found to be expressed in the projective test material as well as in the symbolic play of the younger children. Though frequently the abandonment fears were handled by defense mechanisms of repression or denial (Freud, 1946), there were a number of cases in which these fears were a consciously expressed concern. The patients asked open questions about position in the family, pointing out that the parents were not their "real mother and father," and questioned the nature, character and whereabouts of the biological parents. There was frequent conscious concern about loss of the adoptive parents and there seemed to be more overt anxiety related to loss of collateral relatives or close family friends through death than in a control group of nonadopted patients. (Anxiety related to loss was present in the control group but at a more unconscious level.) There was a high incidence of symptomatic behavior such as running away, rebellious, defiant behavior in school, or ritualistic or obsessional behavior manifesting itself whenever the parents were absent from home together.

Another predominant theme which was usually consciously experienced and verbalized by the patients was a deep sense of inadequacy and inability to meet parental expectations. Guilt feelings were marked with regard to school nonachievement.

Special Problems in Adolescents

Identity crisis was present in all the pubertal and adolescent patients. The question of "Who am I; What am I; Where did I come from?" was expressed in 13 of the 22 patients. Since this question is common in most adolescents, we feel the significance of this in our adopted patients lies in its greater intensity, conscious expression, and the reality of the questions for the adoptee.

We found that in five out of the ten pubertal and adolescent patients in treatment, there was some identification at an unconscious level with a parent pregnant out of wedlock. This included both males and females and was viewed as non-ego-syntonic by the patients. Schechter (1964) reports one case with such dynamics. We consider this to have been fantasy material since the patients did not have access to information regarding their biological parents. It also reflects, however, their increasing sophistication and exposure to peers who were experiencing illegitimate pregnancy, with each patient being aware of the great likelihood of his own illegitimate conception because he was adopted. One patient, a male, 16 years old, who was referred to a male psychiatrist and is not included in the 22 patients of our study, was most rejecting and unaccepting of himself during the psychiatric examination because he recognized that he might be the product of an illegitimate conception. This realization was the trigger that provoked intense anxiety and led him to request psychiatric help.

The conscious and unconscious self-disparagement that we found in our adolescents frequently led them to develop a peer group from a socioeconomic and cultural level below that of their families. This dynamic is manifested in many nonadopted adolescents who suffer from deep feelings of inadequacy. In the adoptee's situation it plays into some of the dynamics present in the adoptive parents, creating an especially intense emotional "reverberating circuit."

Younger adopted patients showed emotional immaturity and dependency. They were materialistic and clung intensely to material objects. They identified strongly with animal pets, and events occurring to the pets seemed to carry marked emotional significance. We did not find a comparable phenomenon in our control group though there were instances of marked involvement with pets. For the adoptee, the pet is another adopted member of the family with whom he identifies but not a rival as is the case with another adopted sibling.

Characteristics of Parents

In our study of 20 sets of adoptive parents, we found a number of distinguishing characteristics when they were compared with a control group of non-adoptive parents. This includes age at the time of becoming parents. Adoptive parents in our group were, on the average, ten years older than the non-adoptive parents upon obtaining their first child. This is similar to findings reported by Kadushin (1966). We further found that, in general, adoptive parents had been married at least five to ten years before the introduction of a child; whereas, nonadoptive parents tended to have their first child within the first five years of marriage.

In exploring the reasons for childlessness leading

to adoption, no medical cause had been found in 12 of the 20 families; of the known causes, only three were related to the father.

The motivation for adoption seemed to fall into two major categories: first, the genuine desire to have children; and second, the desire to fulfill social roles and cultural expectations. Lesser factors were the desire to be charitable, to provide a companion for a natural child, and to cement a failing marriage. We viewed these latter three factors with concern; for motivation, in general, is considered an important factor by all who have studied adoptive families. It does indeed influence parental attitudes toward the child and does determine the degree to which the child is considered a true member of the family.

There was a more intense need for adoption in the mothers than in the fathers. Theories related to inter and intra psychic factors producing this need have been presented in the literature (Schechter, 1967).

As compared with the control group, our adoptive parents appeared to have a slightly higher estimated intelligence, a somewhat higher actual educational experience in both the mothers and fathers, and a generally higher socioeconomic level than nonadoptive parents seeking psychiatric help—even for a private practice.

Vulnerability of Parents

We found no specific distinguishing personality factors with one exception: adoptive parents have all the hopes, expectations, worries and concerns of nonadoptive parents, but they seem to have them to a greater degree of intensity. In our study of 20 sets of adoptive parents in treatment, as compared to a control group, we found that adoptive parents do seem to feel a heavy sense of obligation to the child entrusted, by petition, to their care. We found this overdetermined sense of duty, which does contribute to rearing difficulties, to be the only truly significant difference between the two groups in terms of parent-child interaction which could be related directly to the adoption experience. We have labeled this phenomena *higher vulnerability level* (HVL). While HVL presents itself in various forms, it appears more well defined in adoptive mothers. It is also seen in relation to several other characteristics which, while present in the control group and related to factors other than the adoption experience, appear to have an enhanced impact in the adoptive family situation.

Tendencies enhanced by HVL include overindulgence. There is a flavor of a need to please the child or in some way to compensate for the child's deprivation of natural parents. There is a need to treat the child as "special"—the Chosen-Child Syndrome (Schechter, 1960)—which tends to "isolate" the child within the family setting. This was found to be

especially true in families where a natural child was present. Adoptive families displayed marked vigilance and overprotectiveness in order to secure their position as good parents. They tended to suppress the expression of their legitimate and realistic negative feelings, particularly anger, lest they be viewed by the child and society as rejecting. At the same time, they overreacted to the rejecting expressions of hatred and anger hurled at them by their adopted child. We found it of considerable interest that in those families with natural children as well as an adopted child, expressions of anger and rejection from the natural child were more readily tolerated.

We found, as is cited in the literature, that a substantial number of our adoptive parents did tend to consider consciously the ever-present "ghost" of heredity and promptly relate misbehavior or any failure to meet parental expectations as evidence of the child's in-born inadequacy (Reese and Levin, 1968).

Adoptive parents overlook the fact that though they may provide love, nurture, environmental security and sound rearing, their child may always have moments of loneliness when he, from time to time, must deal with the initial abandonment by the biological parents. These moments leave adoptive parents with intense feelings of helplessness not precisely similar to the feelings of helplessness confronted by natural parents.

We noted an extremely high level of expectations in the parents with regard to the child's behavior and performance. They wanted a "good" child who performed well, as a confirmation of their stability and success as parents. Though this same phenomenon is present in natural parents, it is not so consciously expressed nor its frustration so consciously discomfiting as in the adoptive parent—especially the adoptive mother.

It has been suggested by Kadushin (1966) that the sensitivity of adoptive parents influences the willingness to seek professional counsel. This may be related to the initial adoption experience, ie, they sought help to obtain a child; therefore, the experience of seeking assistance is a familiar one. Thus, while the negative aspects of HVL are present, one exceedingly positive aspect may also be related to it. That is, due to the presence of HVL, there seems to be greater investment in the therapeutic process on the part of adoptive parents, again, particularly adoptive mothers. Their very eagerness to do the right thing for the best interest of their child tends to contribute towards workability, movement and speed of progress in therapy.

Summary

We have presented those characteristics of 22 adopted children and 20 sets of adoptive parents viewed as special by a team of child psychiatrists

and a psychiatric social worker in a private setting. Material derived from psychological test protocols was included in the study. No attempt has been made to statistically validate the findings and the presentation has been descriptive.

The reality of an abandonment experience would appear to be a major element in the anxiety experienced by the adopted child. This source of anxiety is the one element that distinguishes the emotionally disturbed adopted child from the emotionally disturbed nonadopted child.

We did not find adopted children in our practice to be more severely emotionally disturbed than the control group of nonadopted children.

Adoptive parents tended to have a higher vulnerability level (HVL) to the stress of child rearing which was reflected in overdetermined reactions to the life experiences of their child; but this rendered them sensitive and invested subjects for psychotherapeutic intervention.

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Elective Mutism in Childhood*

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Introduction

Elective mutism was first described in the literature in 1877 by Kussmaul who used the term "aphasia voluntaria" in order to describe children who, though not severely disturbed, are willfully mute for purposes they refuse to disclose. From this time until the 1930's there was very little else in the German literature. In 1934, Tramer coined the name "elective mutism" which has gained a world wide acceptance. More recently in the German literature there have been papers by vonMisch (1952) Spieler (1944) and Weber (1950). Spieler, in his review of 50 cases of elective mutism, came to the conclusion that a "neurotic personality" was the outstanding feature in the mute children. In 1945, Tramer interpreted the behavior as "an archaic defense reflex retained for an abnormally long time." Weber's four cases were compared by vonMisch in his paper in which vonMisch also had a number of observations. They were: 1) environmental factors may precipitate mutism; 2) mutism often occurred upon the child's separation from the family, especially at the time of his entry into school; 3) while possibly hereditary and intelligence factors might play some part, the disorder was basically psychogenic; 4) all cases demonstrated excessive ties to mother; and 5) the selection of mutism is a symptom with possible relation to traumatic experience at the time when the child was developing speech. Galnzmann, a Swiss pediatrician, also described the "anal sulker syndrome," the three main symptoms being: 1) mutism, 2) urinary retention, and 3) voluntary retention of stools.

The first major report in the English language literature was made by J. D. Salfeld in 1950. He reported the following observations: 1) the onset of elective mutism occurs between 3 and 5 years of age; 2) there is no mental defect; 3) there frequently seems

to be a familial factor; 4) there is a relatively great resistance to treatment; and 5) there may be early somatic psychological or compound traumata. Adams and Glasner, (1954) emphasized that the children in their cases came from severely disturbed home situations, were unable to develop trust in their parents, were slow in toilet training, and despite the ability to hear and understand the spoken word, used pantomime and peculiar sign language to communicate. In a paper in 1963 Browne and associates reported that these children appeared to be either fixated or regressed at the anal stage of development. Their manifest behavior in many ways reminds one of a child of two years who cannot speak to people other than those with whom he is familiar. They utilize muteness as a weapon to punish people who have offended them. There appears to be a neurotic split in the family with the mute child identifying with one of the parents in an ambivalent symbiotic relationship. Pustrom and Speers (1964) felt that elective mutism was but "one of several manifestations of the neurotic disorder found in these children" which includes school phobia, enuresis, food conflicts, preoccupation with cleanliness, obsessive compulsive attributes, problems in self-identity, withdrawal and depression. The common factors in these cases that they reported concerned conflicts regarding mutual dependency and revealing family secrets with fear of retaliation from parents. The most recent report in the literature was that of Wright (1968), but unfortunately this article only dealt with children who would not speak in school and the usual diagnostic criteria for elective mutism were not followed.

Over the years many children have been referred to the Virginia Treatment Center for Children in Richmond with the symptom of mutism. The mutism fell into a number of diagnostic categories—schizophrenia, hysterical aphonia, brain damage, degeneration brain diseases, and elective mutism. Our experience with five children with elective mutism is as large a sample as can be found in the American literature. As criteria for the diagnosis of elective mutism

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the following were used: 1) The children would speak only to the immediate family and close friends and would not speak to strangers or in school. 2) The symptom was not a transitory one and had to exist for a period of at least two years. 3) The symptom would not yield to the usual blandishments that one would use to entreat a child to speak. 4) No severe underlying psychopathology or demonstrable organic disorder could be present. 5) The children must at least be functioning in the average range of intelligence.

Case Summary—*Eric*

Eric, a thirteen year old boy, was referred to us in 1963 by the Juvenile Court at the suggestion of a local mental health clinic. History at the time of the evaluation was that Eric had not spoken to any adults for seven years and had not spoken to his parents for five years. The only communication he had had was with his siblings. The cessation of his speaking had to do with his being hospitalized for abdominal pain. Previous to this he was supposedly a happy, affectionate, talkative youngster who seemed to get along well with other children and members of his family. Very interestingly the symptom came to be referred to us not at the request of the family or parents but when this rather unusual symptomatology was noted by the personnel of the Juvenile Court.

The patient was the fifth of eight children in a very chaotic family. The father, a career Army man spent little time at home and the mother was a rather inarticulate depressed lady who has very little in the way of internal resources. Even as the therapy evolved with the patient she was, for the most part, still unable to gain any insight or to work at all on her difficulties in relation to her son. There was no contact with the father during treatment.

When Eric was initially seen, he was felt to be an extremely angry boy who seemed quite angry with the world in general and toward adults in particular. He seemed to feel, partially because of his small size, that he was inadequate, unable to compete with peers, in danger of being injured and in general, small, helpless and infantile. Although testing was then incomplete because of his unwillingness to talk, he was thought to be of average intelligence. It was also felt that there was some degree of anxiety and depression in this boy.

It was recommended that this boy enter in-patient treatment and he was hospitalized in September of 1963 and discharged in June of 1964. It was felt at the time of admission that Eric could certainly utilize the hospital situation as a place where he could rebuild his life, and it was hoped that at the time of discharge he would not go home, but would be placed in a foster home. It was felt that the Treatment Center could offer him a safe haven which was some-

thing he had never really experienced during his entire existence. It was felt that in view of this he would be able to learn to trust people once again and begin to talk. The improvement in the hospital was a gradual one. At first he was quite negativistic, withdrawn and would not relate even with his peers. Gradually, his peer relationships improved and he began to communicate with his therapist by notes. Gradually the notes disappeared and he began to whisper into a dictating machine when the therapist was out of the room. As time passed communication was carried on by telephone with the boy being in one office and his therapist in the other. This then went to the therapist sitting in one room with the boy in another with the door slightly ajar. Finally, after many months he was talking directly with the therapist and at this time he began to talk to other staff members in the Center.

As the material unfolded it became quite obvious that this boy had had much deprivation and conflict. He talked of the extreme deprivation in terms of food, warmth, and of tremendous angry feelings toward his father who would abandon the family with great regularity. He related that the family situation was oppressive, and that he was constantly told to "shut-up." One day he finally decided it would be the safest thing to do. He said that when he talked, "it got me in trouble" and he decided to stay silent which he had done for about seven years. With the advent of his talking, there was a great improvement in this boy and he showed across the board improvement in everything from school work to athletics.

At the termination of treatment, this boy had been placed outside of his home with an aunt and uncle and had resumed speaking.

Case Summary—*Dan*

This thirteen year old boy was referred to the Treatment Center in May of 1965 with an extremely interesting history. After a normal birth and development this child did well until age 2½ when his father left the home and the family situation deteriorated. This caused marked alterations in Dan's behavior and he gradually became more withdrawn and mute. His mother also became extremely withdrawn and depressed at this time. At age six years he was not able to enter school because of his withdrawn, unhappy state. At age seven he entered school and completed the school work although he still was not able to talk. In April of 1959 when Dan was seven, he was seen in the psychiatric clinic at the Medical College of Virginia. He also was seen at a guidance clinic for a brief period of time and finally was hospitalized at a State Hospital from June, 1960 until August of 1963 and was said to have improved. A great deal of this withdrawn behavior disappeared and he was able to complete significant classwork without talking. After

his return home, he again went to his local school and did not talk but was able to keep up academically. In January of 1965, Dan sustained an eye injury and was hospitalized at M.C.V. Once again the issue of the elective mutism was brought up and ultimately he came to the Treatment Center for evaluation and admission. He was hospitalized from August of 1965 to October of 1965 and then followed as an out-patient until June of 1966. During this time in the hospital he could not relate very well to other children and again was unable to deal with the speech problem. His mother was a rather helpless individual who did not seem to be able to help him with his problem.

Following his hospitalization and out-patient care, he was lost briefly to follow-up, but approximately six months later we received a report that he had had a confrontation with the police after allegedly stealing a car. When threatened by a policeman that if he did not talk he would be taken to jail, Dan immediately began talking and since then has had no further difficulties with elective mutism.

Case Summary—*Sarah*

This child was first seen by us in January of 1967 with a history that at age three or four she had not spoken to people outside of the home. The child had been seen in a variety of settings including school and a local guidance clinic but without success. Because of the prolongation of the symptoms over a period of some three to four years she was finally referred to the Treatment Center for an evaluation and treatment.

The patient was the first child born of her mother and father who were ages 26 and 25 respectively. The father appeared to be a rather mature, well put together individual but the mother at the time of the evaluation was thought to be grossly disturbed having a great deal of paranoid thinking. There was a tremendous amount of marital discord in this family. The parents presented a history of early feeding difficulties with mother unwilling to continue breast feeding the child and a great deal of difficulty in toilet training which was accomplished both day and night at age twenty months. When Sarah was three years old, a sibling was born and a great deal of sibling rivalry came to the surface. A half a year later the mother decided to go back to work for "her mental health," and Sarah was left with a neighbor. At this point her well developed speech pattern in terms of social interaction stopped. In the ensuing four years she was, at first, a very withdrawn, sullen child who would not talk, and then later became an extremely aggressive, rageful, destructive child who would talk to no one except her immediate family. In the public school situation she could not handle her relationship

with other children very well and tended to be a loner and was quite isolated.

She was ultimately hospitalized at the Treatment Center in September of 1967. At the time of admission it was noted by the child's therapist that the parents seemed quite pleased in some ways about the controlling behavior of their daughter and how successful it had been.

Once in the hospital it was noted that Sarah used some of the children to do her talking for her much as she had used her brother. This interaction with peers excluding adults appeared to mirror the relationship she had had at home. When it became apparent to her that the staff would not behave as outsiders had and allow her to use other people to communicate for her and/or use signals instead of words, she became quite rageful. She went through a prolonged period of destructive behavior with extremely regressed parts such as urinating on the floor. Gradually this abated and the child moved into some significant and hopefully corrective relationships with people. As the year of residence drew to an end there was again a great deal of difficulty with the parents, and the child, in spite of the gains that she had made, had begun to exhibit once more a great deal of regressive behavior with a marked decline in her verbalizations.

After she was discharged the parents made it quite plain despite multiple contacts by our agency that they did not wish to have anything further to do with the Treatment Center. There was contact with a psychiatrist who informed us that the family had undergone further upheaval and that once again Sarah was having difficulty in talking to people outside of the home.

Case Summary—*Becky*

This seven year old child was first seen by us in June of 1967 with a history of not having talked for a period of at least two years. This child, a ward of the Public Welfare Department, had come into their charge some two years before with a history of severe deprivation and an extremely chaotic family existence. At that time, she was not talking and the history was unavailable as to how long her problem has existed. It is known that in her past history there were multiple separations and other such difficulties.

Once in the hospital situation Becky slowly, but surely, began to form relationships with various people. Her obvious deprivation and lack of somebody to relate to became manifested in her clinging to any person who came along. Finally she began to start developing some reasonable peer relationships and gradually began to enter into the program. After a period of time it was noticed that she did begin to relate, by whispering, to the other children. This gradually spread from whispering to the children, to

the staff, and then to her therapist. It was obvious that this child was quite mistrustful and her non-talking was a way of not getting emotionally involved with people. It was also increasingly evident that once she had felt some security in her relationship to people and could honestly begin to believe that the staff of the Treatment Center were there to help her and not to deprive her further, she began to start with verbal behavior.

As part of the overall treatment program, we felt that it was necessary for her to have a stable home situation. Finally a family was located and she managed to relate quite well to them. After a series of visits with these people, she was ultimately discharged from in-patient care to the family. Later reports indicated that she was developing quite well in her relationships with the family and in her abilities to verbalize.

Case Summary—Charles

Charles, who is age twelve, was originally referred to the Treatment Center field-unit in 1967 by a County Health Department. Evaluation revealed that he had not spoken publically for the past three years. It would seem that his symptom began one day in the first grade when he was allegedly told to sit down and shut up. Immediately following this, Charles defecated in his pants and was told to stand outside for the rest of the day. After this incident, he refused to talk publically to any peers or adults. Up until his admission he had only continued to converse with his siblings and his parents.

The family constellation is an unusual one. His father is an extremely damaged individual who is suffering from a chronic mental illness and has had emotional problems since World War II. He has made numerous trips to the Veteran's Administration Hospital and receives a service connection pension for his disability. Charles' mother is a rather old looking, care-worn lady who runs the household. She is intimately involved with the children and extremely overprotective. She is not an unintelligent lady and has been aware for some time of her son's troubles, but until the present has been unable to divorce herself sufficiently from them to bring him into treatment. Charles has a half-sister age 14, by the mother's first marriage (which ended with her husband dying) and a younger brother, age 9. Neither of these two children has any overt emotional problems.

Over the years intense pressure has been applied to this family by various sources in order to gain some treatment for Charles. In February of 1968, he was removed from his home by the Court and placed with an uncle and aunt where he underwent the remarkable process of socialization. The aunt writes in her letter that he could not use eating utensils, did not have very much in the way of schooling and

etiquette, and had only the most primitive concept of the use of bathroom facilities. During this time, he showed remarkable improvement in his behavior, became much better socialized, developed manners, began to be much more self-sufficient but in spite of all this, Charles still did not talk. Because of the pressure that the parents put on the Court, he was finally allowed to return to his home although he was still legally a ward of the Welfare Department. Local out-patient psychiatric treatment was attempted for a period of time but without success.

The parents decided to seek evaluation in December of 1969. The diagnostic was a rather unusual one and consisted of talking with the parents and taking them on a tour of the Treatment Center. The parents had finally come to the realization that their son would indeed need some help in coping with the world and that they would not be around to do this for him. Their greatest fear became verbalized during the diagnostic. Would Charles be treated in the same manner as his father had been treated in a large mental hospital? At the time both of the parents were quite surprised about the program we had at the Treatment Center and this has been borne out in repeated conversations with them.

Charles' isolation from his peers is in many ways similar to his family's isolation in a social world. These people live in a fairly inaccessible part of a scarcely populated county. They have little contact with outsiders except for some extended family in the area. They are terribly unsophisticated people and are quite frightened of authority figures, and outsiders.

Once he was admitted to the Treatment Center there was a great deal of initial difficulty encountered. He had no means of communicating except with hand gestures and when nobody understood this he would immediately break down and cry. It was felt that the first thing that should be done in terms of dealing with his non-verbal behavior would be to have him stop the gesturing and begin to at least use words if not in a verbal way, non-verbally. In order to do this we began by telling all persons coming in contact with Charles not to respond in any way to his non-verbal communications. We then gave him a deck of cards with careful instructions on how to use them. Various words were on them such as yes, no, snack, bathroom, school, food, etc. He began to use these cards, and for this began to receive the usual rewards. This was accomplished by a great deal of frustrated crying and rage, but he finally was able to accept the use of the cards and to make his way into the social life of the unit with them. As we moved from this to the next step, we began taking away various cards from him and replacing these by having him mouth the word which was on the card such as snacks, bedtime, courtyard, etc. This worked to the

point that he was finally able to give up all the cards and could mouth anything to anybody on request. The greatest hurdle was getting him to use sounds. It was important, it was felt, to find the adequate reward to help him give up his behavior. Finally it was discovered that Charles had a tremendous propensity for fossilized shark's teeth and he was given the opportunity to earn some of these shark's teeth by making sounds. This proved most successful, and he then began to start making sounds which gradually evolved into words. He has moved steadily along into social interaction within the hospital. At the present time, Charles is now conversing with peers and talking in sentences to adults within the Treatment Center. He has also begun to speak with some of his extended family who have visited with him with great regularity. It is felt that further cooperation with his school is necessary to help handle him once he is at home.

Discussion

All of the five children that have been seen throughout the years at the Treatment Center have come from disturbed home environments. In four of the five cases (Eric, Dan, Sarah and Charles) one of the parents was grossly disturbed and in the fifth case (Becky), although the family was never seen, the referring agency thought both of the parents were disturbed. There appeared to be a marked disturbance in the parent-child relationships in each of these families which, it was felt, was directly related to the degree of family disorganization and psychopathology present in the parental figures. It was felt that this was etiologic in the onset of the mutism which occurred concomitant with some degree of separation from the parental figure. In Eric's case this was a hospitalization at age five; in Dan's case this was intermittently related to the father abandoning the family and the mother becoming depressed and withdrawn. In the case of Sarah, this occurred by the mother's returning to work; while in Becky's case, the abandonment of this child occurred by her family. Finally, Charles' problem developed by the separation of going to school.

Formulation

From the literature it would seem that the various people observing and reporting elective mutism seem to be split dynamically into two groups. The first group consisting of vonMisch, Salfeld, Adams and Glasner, take the view that the primary difficulty appears in the oral stage of psychosexual development and is intermittently related to difficulties in object relationships. The other group of Glanemann, Brown and Pustrom and Speers, espoused the view that the root of the psychopathology is in the anal stage.

It is our considered opinion that although much of

the surface behavior appears to have to do with anal level difficulties characterized by compulsive withholding with a need to control the environment, the children we have seen have primary difficulties in the oral stage of development. These children suffer from an impoverishment of object relationships; they cannot tolerate separation, and they do not relate because of the fear of rejection. It is also felt that these children are quite empty and their ability to give is markedly limited. This view is not dissimilar to many of the ideas espoused by Ericson about the oral retentive phase of psychosexual development. It is felt that these children in part are arrested at this particular phase; and the treatment is necessary to help them move beyond this area of fixation.

Summary

Five cases of elective mutism seen in the Treatment Center over the past eight years have been reported. Fairly strict diagnostic criteria have been laid down and a comparison of the cases in the literature has been done.

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Psycho-Social Aspects of Drug Abuse by Modern Youth*

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Research in human behavior rarely lends itself to the scientific rigors which allow for definitive cause and effect answers even if they exist. Perhaps no facet of human life has a simple origin, and certainly that is true of behavior which involves all levels of personality function and social interaction such as occurs in drug abuse. Drug abuse undoubtedly is overdetermined behavior with multiple etiological factors in a constantly fluxuating interaction. Most observers agree that drug abuse by the youth has become a major problem, but differences arise when the sociological and psychological factors of etiology are discussed. The many concepts of etiology are more or less products of the individual observer's orientation and past experience, and therefore, they rarely are subject to cross validation.

It is essential to keep an open and skeptical approach and to avoid a single-minded dogmatic view which may lead to misidentification of the enemy and to corrective moves which are doomed to failure and which only further compound the situation. The immediate response of more stringent legal and punitive measures made by many of our communities is an example of this type of a move and its self-defeating nature.

The definition of the problem is, in itself, very indistinct. Is drug abuse a condition, a symptom of a condition, or a sign such as edema in cardiac failure? The adolescent user tends to disagree with all these possibilities. When does drug use become drug abuse? The adult definition, by and large, differs markedly from that of the adolescent. The 17 year old who smokes marijuana only on Saturday night

does not classify himself as a drug abuser, but he might so term an acquaintance who used the drug three times a week.

There are some areas of general agreement, however. We know that the per capita number of youthful drug users has risen markedly in the past decade. Drug use is seen at earlier and earlier ages, and there has been a change in the socio-economic status of the users of hard narcotics. For example, heroin use among middle class teenagers was quite uncommon three years ago, and it was an extreme rarity five years ago. It is now estimated that one to two percent of college students on the northeastern seaboard have used heroin to some extent, and the number of high school users from middle class families is continuing to increase.[†] The major concern with non-narcotic drug use was at the college level in 1964, but by 1967 it had become a concern in high schools, and today it is a problem of note at junior high levels. Parenthetically, the increase in the use of mood altering drugs by the young people has been paralleled by a rise in the suicide rate of adolescents in the last decade (Ross, 1969). Drugs were the major cause of adolescent deaths in New York City in 1969.

Let us examine some of the phenomena that may be operative in the behavior of today's youth and relate them to drug use. Each factor, obviously debatable, may bring to mind others of equal importance, and specificity and completeness are patently impossible.

Television is a form of sensory input with effects upon development still largely hypothetical. Dr. Sam Hayakawa of San Francisco State University, in a statement published in the *New York Times*, estimated

* Presented at the Eighth Annual Spring Forum for Child Psychiatry, May 29, 1970, sponsored by the Virginia Treatment Center for Children and the Division of Child Psychiatry of the Medical College of Virginia.

[†] Unpublished random survey done at Rutgers University, Department of Student Health, 1969.

that the average 16 year old has spent about 20 percent of his waking life watching television. This makes it quantitatively the greatest single influence impinging upon his developing central nervous system at the most crucial time. This influence virtually begins at birth and may be capable of programming the individual nervous system with attitudes and expectations which form the base of all future learning and behavior. The concept of imprinting demonstrated in lower animals cannot be translated directly over to man, but the possibility of a similar process spread over a longer period must be considered (Lorenz, 1952). Certainly there is evidence that the basic concept of gender identity is fixed before three years of age and that change rarely can be produced even when genitalia contradict assigned gender (Money, Hampson and Hampson, 1957). Basic personality disorders appear to be a product of the early years and to resist our efforts to change them. Other attitudes toward and ways of approaching life may be equally indelible and even more fundamental.

Television teaches the developing child that pleasure and gratification of his senses can occur instantaneously without his active involvement or expenditure of energy. The possible and the impossible are not sharply delimited, and the development of ego boundaries might be delayed. There are no reality limits to the world of fantasy, and magic beginnings and endings become a normal part of living. One simply turns on the machine, and ergo, one lives with an ever available Alladin's lamp. The drug culture was quick to adopt the phrase, "turn on" as indicative of an approach to life which includes gratification without effort or responsibility. "Tuning out" is another television phrase adopted by the drug culture to indicate an escape from reality living. It is possible that one of the earliest, the deepest, and the most indelible concepts imprinted upon the mind of today's youth is that of the ease and desirability of instantaneous and passive sensory gratification.

Television also furnishes the child an unlimited and ever-changing supply of identification figures and role models that are far more tangible and believable than those from a book or fantasy. The incorporation of these figures and their unreal or deviant characteristics could produce a major effect on the development of ego ideals and the super-ego.

The child reared in a television civilization also grows up in a nuclear family in which there is decreasing ability to escape the intensity of the family triangle. Industrialization, urbanization, and geographic mobility have all but destroyed the extended family of the past. An escape from the oedipal situation into the support of grandparents, uncles, aunts, cousins, and so forth, has become less and less possible. The family as a culture transmitter and as a microcosmic world in which to experiment with

future roles is becoming history. The television world first, then later the peer group and the school system with its teachers, counsellors and social workers, have become inadequate replacements for the old extended family. As family structure and authority has waned, these outside groups, always of great significance, have become more and more important to the developing child as sources of learning, support, guidance, and as repositories of values and standards.

These forces and social changes are part and parcel of almost unlimited affluence and complex technology. This affluence has produced not only an abundance of material goods and bodily comfort, it has had the even more important side effect of reducing the opportunities of the growing child to achieve mastery. Self-esteem is derived from many sources from birth onward, but one major origin is the growing organism's experience of overcoming frustrations and achieving goals by its own energy and activity. The more affluent the society, the less the opportunity exists for constructive mastery on the part of the young. Society will, in fact, discourage attempts at mastery when they conflict with what passes for progress, advancement, and social status. Children and young adolescents come to recognize that there is no constructive role for them to play in an affluent and crowded society which literally does not need people. For example; one junior league baseball team met one Saturday morning in the spring to clear its field of weeds with blade and sickle. This was vetoed by the adult leaders who quickly and efficiently cleared this field with power mowers. The children were denied an opportunity to master a task of great relevance to them and to achieve a notch toward self-growth.

Mastery and its attendant ego-growth through achievement may be associated with the relevancy of the task. An event or action which contributes fundamentally to the welfare of the family or the social group is worth far more than one contrived by well meaning adults to keep the youngsters out of trouble. Many of the activities of youth in an affluent and urbanized society are either contrived, aimless, or totally hedonistic. Not only do they rarely contribute to the welfare of the social unit, but they usually are obviously added expense and burden and/or furnish vicarious pleasure for the adults involved and are, therefore, self-defeating.

Our youth have approached adolescence larger, stronger, and intellectually brighter than ever before. Peter Blos, in his book, "On Adolescence," states that the period from puberty to adulthood is the time of experimentation and trial which leads either to mature resolution of childhood conflicts or to some form of compromise which ranges from a mild character disorder to a complete disaster (Blos, 1962). He states that the creativity and the imagination of

the human reach a peak during these vital years. Eugene Pumpian-Mindlin adds to this the concept of omnipotentiality as a characteristic of the normal adolescent (Pumpian-Mindlin, 1965). This refers to a boundless feeling of invulnerability and power not dulled by conflicting reality. Combine the concepts of Blos and Pumpian-Mindlin and you have a situation in which boundless energy, creativity and imagination are urged onward by a sense of power and invulnerability which does not recognize reality limits or time boundaries. All things are possible and future consequences of present behavior do not exist, or they must, by definition, exist only for others. This should tell us something about danger and punishment as deterrents to adolescent behavior.

Blos foresees a permissive and unstructured adolescence as producing adults of great potential for creative thought and imaginative living. A harshly limited and controlled adolescence, on the other hand, produces rigidity, inflexibility, lack of imagination and creativity—in other words a conformity to authority which we do not like to contemplate. It sounds, therefore, as if a totally permissive adolescent period is very desirable unless one wishes to crush and to warp those traits which symbolize progress and advancement in human interactions. There is, as one might expect, a catch to this otherwise obvious choice. Blos also states that there is a price to pay for the totally permissive and unstructured situation, and that price is a certain casualty rate among the young experimenters. The lack of reasonable structure and protective limits produces a high risk—high gain situation in which many simply will not survive.

Blos and Mindlin are referring to characteristic attributes of normal teenagers. Their concepts imply that the adolescent tends to ignore and to deny reality factors when they conflict with his fantasies and/or his desire for the pleasure principle and that he tends to depend upon his own private interpretation of the situation. The process of maturing necessitates some degree of structure and guidance, broadly flexible, to prevent damage and/or deviance in development. Unfortunately, the post World War II years have seen a marked decline in parental influence and responsibility. By and large, the youth have been free to explore, to experiment and to act without discipline and regulation. Old values and standards were dethroned before heirs were chosen to take their places. Society approached a state of anomie; a state in which normative standards of conduct and belief are weak or lacking. Durkheim spoke of anomie in the individual as a lack of society's influence on the basic passions, therefore, leaving the individual without a check-rein on behavior (Durkheim, 1951). He felt that this was a major factor in self-destructive behavior. The phrase, "doing one's thing," may be a concept which stems from a positive value upon and a

desire for individual freedom, but it also may be an anomic concept derived from the lack of the social and cultural guidelines that give one a sense of belonging. Perhaps the latter concept is more accurate when "doing one's thing" implies socially disapproved or destructive action.

These psychological influences and social changes have gone hand in hand with a concentration on the alleviation of discomfort and anxiety by external means. Madison Avenue has capitalized upon this trend and has flooded the media with encouragements to take Compoz for tension, Sominex for insomnia, No-Doz to awaken the next morning, and Alka-Seltzer for the discomfort caused by the other pills. The youngster, with a nervous system which is attuned from birth to the reception of television messages, has incorporated both the desirability of and the means of escape from discomfort into his basic concept of living. He learned so well to alleviate anxiety by oral means that he discovered new and more effective ways, and he improved upon the adult example by developing his own brand of tranquilizers and stimulants. One of his major methods of tranquilization, marijuana, not only is highly effective pharmacologically, but it also has the extremely important side effect of increasing the anxiety and tension of the adult world while it decreases his. He simultaneously thoroughly agitates his parents and other representatives of authority while becoming the central focus of society and its communication media. All the needed ingredients for positive reinforcement of behavior are present to insure its continuance.

The adolescent not only is able to defend his position on drug use with strength derived from adult examples, he simultaneously cannot develop the type of world perspective common to his elders. There are many factors operative here, but one is that today's youth are part of the first generation to see history as it occurs. Past generations learned of the major events of civilization after they had been embellished and distorted so as to obscure motives and to rationalize behavior. Good and bad were divided into definite camps in which the hero always won and the stranger was the villain. This can no longer be done to those who have a ring-side seat to history in the making via the television screen. All the frailties of adulthood and its world are laid bare so as to destroy the idealized image of childhood and to leave no God in its place.

Other perfectly realistic factors known to no previous generation have crashed in upon the young person so as to disenchant him with adult values and goals. The word "ecology" has rocketed to importance. Concepts barely mentioned a few years ago, environmental pollution, population explosion, a raped planet, all have become common knowledge of this genera-

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tion. These concepts, now almost axioms, were not invented by the youth, but they were quick to realize their validity and to look with a degree of just accusation and distrust at the adult world that produced them.

It would appear that the markedly increased use of chemical measures, either as a negative escape from reality or as a positive flight to the pleasure principle, is understandable if these hypotheses are correct. This does not mean that it is desirable unless one assumes a completely hopeless stance. On the contrary, survival in the future may require a degree of maturity and stability greater than ever before. This maturity requires the process of adolescence with its mastery of anxiety provoking situations, its search for a role in life, the amalgamation of sexual identity, and all of the attendant pains and discomforts. The adolescent period is one of emotional liability and transition during which the teenager is coming to grips with conflicts and confusions which, by their solution, will solidify his self-identity and his future social role (Erickson, 1956). This means that at no other period of life is a brain disorganizing drug more contraindicated. It is doubly dangerous if that drug presents an artificial solution to problems and allows an indefinite postponement of this essential process of reaching closure with one's own search for being. It does not appear logical to encourage an escape from this process of maturation.

Neither does it appear logical to fight an enemy whom one does not understand and to remain symptomatically oriented. If we are raising a group of sick youngsters, which is doubtful, then we must

assume that the contagious carrier is society and that drug abuse is only a symptom. If it is not true that we have a generation of sick youth, then it is possible that their behavior may be understood as a relatively rational response of pre-programmed minds to social and environmental changes of cataclysmic proportions. If that is so, again our attention must be turned toward our social structure. There will be a need for those of us who treat the individual youngster in trouble with drugs just as many of us treated the victims of polio a few years ago, but just as with polio, we must keep in mind that the ultimate goal is the understanding of and hopefully the control of the pathogenic process at its source.

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Problems in Rating Disturbed Behavior*

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Introduction

A maiden lady or shy bachelor may risk savings on an ocean cruise—envisioning romance under the stars, happy laughter, bubbling champagne and even finding a handsome and wealthy life partner. They may end up at home port broke, and with memories of *mal de mer*, finding only that they have spent much money to go nowhere and get nothing.

The researcher runs a similar risk; he may have his vision and undertake an untold amount of work only to find he has not gone far. Even more frustrating, he may find upon the completion of his project that someone else has arrived before him.

Yet, as with the romantic adventurers there is the need for the risk; there is always that chance that the desired goal may be realized and it may be better than even the wildest flights of scholarly fancy would permit. Of course, the adventurers have a distinct advantage over the researchers: if none of their friends or relatives accompany them, when they return home they can always lie. If they lie often enough and well enough about their experiences, in due time, they might even believe themselves. Fantasies are better than nothing on a cold winter's evening.

This past year Dr. Hammett and I have embarked on a research voyage and, if I may be permitted to use the analogy of a cruise once again, we have been on the slowest of freighters. The Ancient Mariner is our spiritual brother. In speaking of the problems of research, one of the problems is time! There are no short-cuts. There has been, for some time, an increasing awareness of the need to look at the causes as well as methods of treating emotional disturbance in children. Because of the addition of new staff members we have been able to undertake this extensive project without having to diminish our services to the children and their families under our care.

The 1956 General Assembly of Virginia which brought the Center into existence recognized the need for research and included this as one of our major functions. Since our first patients arrived, eight years ago, the climate for research has been present and fostered. Over the years of operation, staff members have presented papers at local, regional and national meetings, as well as making substantial contributions to the professional literature.

The project we are discussing here—producing a research form for rating disturbed behavior—proves that there is such a thing as evolution and like man, with all his frailties, has great promise for both the present and the future. Our first attempt at constructing this form was as sophisticated as *pithecanthropus erectus* and as manageable as the Frankenstein monster. In the planning stage it was a wonder to behold. When in our naive enthusiasm we tried it out in the field, we were wonders to behold as we attempted with assured professionalism to complete a six page, three part, 199 item questionnaire. It was unmanageable, frustrating and created such violent emotional reactions in even the calmest of our staff that it was consigned rapidly to an unmarked grave. The greatest success we had in constructing this monstrosity was that we managed to omit the very items which would measure emotionally disturbed behavior in children. Sadder and wiser we returned to planning, while the Center world waited to see what we would inflict upon them next.

The initial step was to define the areas that we wanted to research. Basic to our problem was one large Commonwealth and one small Treatment Center. It is physically impossible to accept every child for whom application is made. Which children should we accept and which ones do best in our program? Throughout the years we have learned to identify the types of children we can help, fairly well; yet our procedure needs to be refined. We want to know: what are the common characteristics of the children? Why do some do well while others do not? Why do some of the children we think are going to do well

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fail, while others about whom we have had grave reservations do very well? Is improvement predictable? These are only a few of the questions we are asking. Even if we were not asking questions there still is a point at which facts, figures and details must be recorded and analyzed in a systematic manner in order to assess programs, plan for the future, and identify both needs and accomplishments. To this end we have developed a behavioral questionnaire which in the recently completed pilot studies evidences great promise, not only for us but hopefully for similar institutions.

An intensive review was made of a number of questionnaires to determine what we felt should be the essential characteristics incorporated into a form specifically designed to measure the behavior of emotionally disturbed children. The criticism of R. N. Dreger (1964) “. . . That most behavior scales are second-order or third-order judgement measures, rather than true behavior measures” came to have special significance for us. We wanted to know how the parents of the children saw them actually behaving. We wanted a *first hand* report, not a second or third-order judgement. Further we realized that any questionnaire to be rated by both the lettered and the unlettered parent must contain simple, unambiguous and specific language. Instead of our asking whether the child “verbalized fantasies,” we ask if he has “imaginary playmates.” That we have succeeded in making our form understandable is demonstrated by the fact that the majority of parents are able to complete it in its entirety. Usually, the questions omitted are those having to do with specific matters, such as dating practices. Parents of the younger children usually will write in, “. . . He is too young to date” although they could check “Always” when the question asks, “Does he avoid dating.”

Brevity and a consistent format were two other essential characteristics. Some of the questionnaires reviewed had as many as 295 items with many subsections. Others shifted in format from a five point rating scale, to multiple choice, to sentence completion and to True and False. A group of us tried out some of these forms on our willing families and found them confusing and time consuming. The untrained rater would not be able to complete them easily with any degree of accuracy. I do believe the same people who revised the recent Federal Income Tax Form must have learned their trade from some of these questionnaires. Even the simplest and most innocuous of forms can be a threat to some. Remember the furor caused by the 1970 Census Form? Parents of emotionally disturbed children are already under severe strain and we did not wish to threaten their

already damaged parent-egos. We did not want them to feel the road to treatment was full of barriers and hazards.

Now, what is a short questionnaire and what is a long one? Of the forms reviewed the average number of questions per form was 100. The fewer items included, the fewer the behavior areas adequately tapped, so we settled on 105 items. In order to offset this ample number of items we avoided overcrowding, which seems to be a common fault of many questionnaires. The blocks in which the parents check their answers are large and, surprisingly, the form looks easy to complete. It is not formidable.

There is nothing more aggravating, when completing a form, than to have something like the following: “If you answered question No. 18 on page 2 ‘Yes’ do not answer questions 27–39 but move on to question 40–69 omitting questions 48–53.” We studiously avoided any such exercise in direction following and all of our questions are seemingly non-contingent items. I say, “seemingly” because the questions are interrelated in order to measure a number of areas of behavior. However, for the rater, how he answered one question has no bearing on how he answers those that follow.

The professional can answer inferential questions. The untrained person will have great difficulty in doing this and so all our items have to do with present, observable behavior; for instance, “wets bed,” “physically attacks adults,” “sets fires” or “will not leave own room.” Soggy sheets, black and blue shins, blazing wastebaskets and a pubescent Peter-the-Hermit are observable. No inferences are needed. All of this behavior is rated on a five-point scale ranging from “constantly” to “never” and we always deal with the child’s present behavior. By using only present behavior we can measure behavioral changes over a specified period of time. The multiple-point rating scale as opposed to the two-point scale of the True—False variety makes it possible to measure changes in frequency of any given behavior over a period of time. It also permits a refined measure of agreement among raters. High agreement among raters is assured also by the use of present behavior. Historical data which is subject to the vagaries of memory can be better obtained in social histories. It is not infrequent that parents, who have a number of children, will become confused in trying to recall which one did what.

The parents are asked to complete the questionnaire at the time of their initial contact with the Center. They complete it again just prior to the Interpretive Interview. By this time, they have brought their youngster in for a diagnostic evaluation. We wonder whether the act of applying and

the diagnostic evaluation in any way effect either the child's behavior or how the parents see their child. The diagnostic evaluation can often be underestimated as to its therapeutic value. It is perhaps more frequent than less that the social worker, when he asks the parent: "Now tell me what Johnny does well," is answered with a surprised look or a comment such as, "Well, I really can't think of anything" or "He colors well" or "He can be sweet." It is not that the parent is callous or ignores his child; the problem is that he is daily faced with so many negative experiences with the youngster that he loses sight of his assets.

If the child is accepted for treatment the questionnaire is completed by the parents, the child's therapist, the parents' therapist, his teacher, and jointly by a nurse and child care technician every three months of the youngster's stay in residence. Upon discharge, the parents and teacher complete the form at intervals of six months, one year and two years.

It has been noted that the form seems heavily loaded on the side of pathology. A basic reason for the development of the questionnaire was to devise a reliable method to help in the selection of candidates suitable for treatment in our setting—not to measure behavioral characteristics of normal children. It will also be used to guide us in selecting therapeutic, and milieu goals; it and will be used to help in studying the effectiveness of the outcome of our therapy programs.

The item selection was based on a variety of commonly stated dimensions and frequently appearing factors of emotionally disturbed behavior in children.

Procedure and Results

The dimensions which guided our selection of items were chosen from several lists of behavioral terms compiled by three members of our Research Committee. A psychiatrist, psychologist and social worker, each laboring independently, listed a broad variety of general terms or categories that they felt described the disturbed behavior of children at the Center. Such categories included, for example: hostility-aggression, depression—self-destruction, withdrawal, sexual disturbance, and learning disturbance. Then, using the lists of categories as a guide, each worker created items of behavior he felt had been characteristic of children at the Center. We will refer to their suggested categories and sub-items of behavior as our original behavior scales. Thus, for example, the original behavior scale of the withdrawal category contains such items as: "daydreams," "avoids people," "hides when visitors come," and "will not talk to children outside of family." The questionnaire has been utilized

in two pilot studies related to the problem of selection of children suitable for short term residential treatment.

Factor Analysis

The first pilot study we discuss was directed at finding out whether we were using appropriate labels to group the 105 items in the questionnaire. It was necessary that the items be grouped into a manageable number of categories. In order to accomplish this, the Department of Biometry of our Health Sciences Center performed a computer analysis of the answers of 159 parents to our questionnaire.* The program requested the computer to select the groups of items having something in common. The computer grouped the items in 18 different ways. The items of one series were found to be mathematically related to each other with hostility-aggression as the clearly predominant content. Items of another collection were found to be related in a second distinct way. The common feature of this second group was depression—verbal self-attack. The computer told us that, for example, the following items had something in common: "threatens to kill self," "threatens to injure self," "talks of how worthless he is," "talks about wanting to die," "overly critical of self," and "is picked on by other children." The third group of related items very definitely had withdrawal as a common characteristic. To summarize, the computer told us that certain items were related to each other in various groups. We examined the content of each group of related items and labeled the group according to what the items seemed to have in common.

The computer method used here is referred to as *factor analysis*. In our case, factor analysis is a mathematical endeavor to determine the number of different ways that our behavioral items can be grouped or classified. It is as though we have a large basket of blocks of different shapes and colors. By examining the characteristics of a particular group of blocks which the computer gathers for us, we might find that the blocks within it are similar in some respect. Thus, for example, they might all be some shade of green. Another grouping might have something different in common, such as the characteristic of roundness. Admittedly, this analogy may not be mathematically sophisticated, but we hope it serves to illustrate the point that the computer identifies the items that group together. We wish to emphasize that in spite of the computer's talents a trained clinician is necessary,

* We are indebted to John Howell and George Cobb of the Department of Biometry for developing the program and performing the analysis.

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with his experience and knowledge of personality and disturbed behavior, to discover and appropriately label the essential nature of each item group.

Following the completion of this factor analysis through which groups of items with a common feature are derived, the next step for us will be to construct scales from each group of items. A child's ranking on any given scale is equal to the sum total of the ratings which his parent gave him on the individual component items. Thus far we have firm basis for constructing scales of hostility—aggression, depression—verbal self-attack and withdrawal. We have distributed to each of five therapists a series of lists of items comprising each of the 18 factor-analytic groupings. For each group, the items are written out in a list one above the other. The items written out higher on the list are those which the computer has indicated contribute more to the particular item group. The therapists will consider this numerical contribution of the items to their groups, in addition to the content of the items, in giving a name to the whole group.

Once the various scales have been named, items will be dropped which may no longer mathematically belong on these scales as shown by a repeat factor analysis with a new set of parents. New scales may be added based upon a factor analysis of questionnaires filled out by Center staff. These scales would apply when the questionnaire is filled out by staff rather than parents.

After the scales have been refined, they will lend themselves as measures of behavior in various studies. The scale scores will aid in providing objective measures to be used in the assessment of the effectiveness of the therapy program for each individual child. This will be accomplished by noting the changes in the child's scores on the scales every three months, relative to his therapeutic goals. For example, one would hope that the level of the withdrawal score of a shy, depressed child would drop and that his hostility-aggression score would rise in relationship to a decreasing score on depression—verbal self-attack. These scores will provide an objective, reliable way to assess progress in therapy. They will also serve as a guide in planning a child's treatment program. For example, a number of children with high aggression scores might be placed in separate classrooms.

Once objective behavior change measures have been obtained, using our scales, they can be used in studies concerned with prediction of therapy progress. It should be valuable to study the scores representing therapy change in relationship to scores on the tests that were previously given to the parents on the day of the diagnostic evaluation. For example, we give the parents the Minnesota Multiphasic Personality Inventory (MMPI). It may

prove valuable in study of the shapes and elevations of the parent MMPI profiles as they relate to the subsequent change or lack of change in their children's questionnaire scale scores. Eventually, we would hope to use this MMPI information and other parent test information in objectively predicting with some validity the child's therapy progress in a short-term residential setting.

Regression Analysis

The second pilot study was also related to the problem of screening of candidates for admission to the Center. This study was concerned with whether the computer could find individual items on our questionnaire which would prove particularly useful in choosing children suitable for short-term residential treatment. The computer's job was to find a small, manageable group of 20 items which would best select treatment candidates. Its next job was to specify the best combination of these items. These 20 items should, when put in a simple formula, best separate children accepted for treatment from those not accepted because they are too disturbed. This classification would be accomplished solely on the basis of questionnaires filled out by the parents on initial contact with the Center.

The formula which George Cobb derived for us using the Department of Biometry computer worked well in separating the cases upon which the formula was based. The separation of 64 cases into the accept and too-disturbed groups would have occurred by chance alone only one time in 100. The formula was then checked for accuracy using a new sample of children. It blindly classified 20 out of 24 children correctly as to whether they had been accepted for treatment or referred elsewhere because they were too disturbed. We concluded that this type of analysis, referred to as *regression analysis*, may prove quite helpful to us. Our regression formula should become increasingly more accurate as it is revised by the addition of more cases as its basis.

We now plan to apply a similar regression analysis program in developing formulae which predict *actual* therapy progress rather than merely the judgements of the Screening Committee and evaluation teams as to *expected* therapy progress. To this end, we plan to develop formulae which discriminate groups of children whose questionnaire score changes reflect actual therapy progress from those children whose scores suggest minimal progress or increasing disturbance. These formulae will have the advantage of predicting therapy change ahead of time in specific areas, such as aggression, withdrawal, and depression, by merely using the questionnaires initially filled out by the parents before the child enters the program. Little staff time will

be required, since the parent does most of the rating, leaving only the scoring to trained personnel.

The feature which the above two studies have in common is the emphasis on predicting therapy progress. The first study will use the parents' MMPI scores to predict therapy changes as measured by our questionnaire's factor analytically derived scales. The second study uses a regression formula, incorporating individual questionnaire items answered by the parents upon application to the Center, to predict therapy change. It is intended that both the MMPI scores and regression formulae scores will be used only as additional aids and will not replace any of the careful thought and evaluation of each individual case being screened. The above mathematical techniques are designed to provide objectives and valid supplements to the present information which the Screening Committee and diagnostic teams have at their disposal in selecting appropriate candidates for short-term residential treatment.

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Variations on the Theme of Depression

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Freud in 1917 published his classic paper on mourning and melancholia describing the essential features of melancholia (depression) as "profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity and a lowering of the self-regarding feelings to a degree that culminate in a delusional expectation of punishment." Much has developed in the knowledge of depression since 1917, but even more has become known about the development of personality and its various stages as well as the psychic structures involved.

If we pass over the work of Melanie Klein who believes every infant goes through a depressive position in the first year of life, we are left with two opposing views about the diagnosis of depression in childhood. These center around the fact that a child before five years of age has not developed a superego (conscience) and therefore "the savage intrapsychic attack of the superego on the ego resulting in loss of self esteem" does not take place as is seen in depressive reactions in older children or adults. To define, the ego refers to the executive portion of the personality which perceives, discriminates and integrates stimuli from the external and internal world. The superego, also a theoretical construct, is that part developed by incorporating standards of the parents and of society as perceived by the ego. The conscience is the conscious portion of the superego, and unconscious prohibitions and ideals are also operative without one's awareness.

The classic work on anaclitic depression by René Spitz (1946) was followed by Engle and Reischmann's case of Monica. In 1951 Bibring saw depression as "the emotional expression of a state of helplessness of the ego." In 1965 Sandler and Joffe from Hampstead Nurseries under the leadership of Anna Freud referred to it as "an effective reaction where a child is faced with a specific type of threat to his well being, whether it be the loss of an essential love object or the thoughts of

having been deprived of an 'ideal state.'"¹ This latter, for example, could happen with the birth of a sibling. They feel that there are many quantitative differences in the manner in which children respond to mental pain induced by such threats. It has been shown that mental pain mobilizes anger although in a child this is often inhibited and turned against the self by the process of identification with the aggressor as is seen in head banging.

It must be remembered that depression in childhood has an evanescent quality in which the obvious signs of depression do not persist openly as in adults. Sandler and Joffe refer to nine items common to depressed children seen analytically at Hampstead Nursery where the material was recorded in the Hampstead Index (1962). I would like to list these:

1. They look sad or unhappy
2. There is a withdrawal with little interest in anything
3. They are discontented with little capacity for pleasure
4. They communicate a sense of feeling rejected and readily turn away from disappointing objects
5. They are not prepared to accept help or comfort even though it is offered
6. There is a tendency to regress to oral passivity
7. There is insomnia or sleep disturbance
8. There are autoerotic or other repetitive activities
9. The therapist often reports difficulty in making sustained contact with the child

I feel that Spitz, Bibring, Engle, Sandler and Joffe and others record evidences of depression in children, taking into account the child's stage of maturation.

On the other side of this contention, Beres (1966) and Rochlin (1959) feel there can be no depression according to Freud's definition before five years of age because of the lack of superego formation. Bowlby in 1960 presented a paper on grief and mourning in infancy, claiming infants react to loss and separation as do adults, although the latter have completed their personality development. This brought forth a storm of discussion from Anna Freud, Max Schur and René Spitz.

* Presented at the Eighth Annual Spring Forum for Child Psychiatry, May 29, 1970, sponsored by the Virginia Treatment Center for Children and the Division of Child Psychiatry at the Medical College of Virginia.

I bring you this brief and incomplete review of the past twenty years to show the confusion about the diagnosis of depression in childhood. I would like to present briefly two cases, both of which I call depression and both of which differ; and as I see them both can be classified clearly under the Sandler-Joffe definition with which I side.

Case Summary—*Laurie Jo*

Laurie Jo, now seven years and three months, whom I have seen for over a year for failure to grow, is finishing the first grade. She is the second of three children with an 18 month older sister and a 14 month younger brother. She was a full term, normal delivery baby weighing 6 lbs. at birth and gaining weight appropriately. She walked at a year and at this time was weaned from the bottle. Her mother felt she seemed quite different "from her older sister" and also felt that she was a very stubborn toddler who refused to be toilet trained at two years of age. Growth proceeded normally until she was two and a half to three years of age, despite the birth of her brother at 14 months. When Laurie was two and a half years, her mother had a depression requiring the use of tranquilizers for several months. Her father at this time changed jobs with a pay cut after he had contracted for a new home, and during this period of family crisis, Laurie began to vomit at night five to seven times a week. She began to wet and soil and to be very constipated. She often choked on food and she screamed without reason for long stretches. When hospitalized for tests at MCV at five years and three months, Laurie showed a height of 35.8 inches, a weight of 23 lbs. and a bone age of two and a half years. She was diagnosed as growth failure based on partial hypothyroidism and chronic constipation. The partial hypothyroidism showed very little evidence beyond the growth failure with the exception of the radioactive iodine uptake which was less than half what it should have been at 24 hours. She was placed on a half grain of thyroid daily for a month, increasing to a grain and later to a grain and a half. In the subsequent four months she grew almost half an inch, gained a pound and a quarter, and was still constipated and without energy, screaming and irritable. The family was seen in our clinic two months later, December 30, 1968, when Laurie was five years and nine months. At that time mother told the worker that Laurie was not happy or excited over her Christmas toys. Laurie was in a pre-school for retarded children and the report from the teacher was that she was showing evidence of some slight increase in her activity. By the time I started seeing Laurie in therapy at the age of six years and one month, she had been moved to a regular private kindergarten on the advice of this pre-school teacher. This move was based on a normal I.Q. I have seen Laurie and her mother weekly through the year and am now seeing them every two weeks.

I agree that she presented some signs of low thyroid activity as evidenced by the deficient radioactive iodine uptake; however, I feel this girl was seriously depressed as evidenced by her failure to grow due to the suppression of thyroid activity after two and a half years of normal growth. Her irritability and withdrawal, the fact that she had no pleasure in toys or play, her clinging, her apparent retardation and, most of all, the very sad affect on her face were all evidence of her depression. It is possible also that her frequent vomiting at night contributed to her growth failure.

When I first saw Laurie she was a tiny, frail child with large blue circles under her eyes. She walked up and down stairs a step at a time, holding the bannister. She clung to her mother when at home, never playing outside with the children. What, however, was most distressing to her parents was that Laurie at times would scream without reason for two to three hours. Mother and father both felt this was unbearable and they excluded relatives from visiting them because of their guilt and discomfort. Both parents felt absolutely helpless when she screamed, and both were open about wanting to beat her. However, this they did not do and it was only with difficulty that they could admit to any but "good feelings" toward Laurie. The father was especially distressed that she exhibited no curiosity or friendliness with him. Laurie was also jealous of her 14 month younger brother who was bigger than she by now.

Because she is tiny and very pretty, Laurie tends to be infantilized by others. There was grave doubt that she could move to kindergarten and later from kindergarten to first grade. Her mother expected both of these to be failures; however, both moves have been most successful and Laurie is in the upper half of a younger section of the first grade. Until very recently Laurie has expected to fail as mother expected her to fail, and it has only been in the last month that she has felt that she would graduate to the second grade. Increasingly her reading has been of enormous pleasure to her. I think at this time it would be easy to think that her lack of development and her depression were due to sibling jealousy for her brother, but they did not commence until she was over two and a half years of age at which time her mother suffered a real depression. In therapy there seems to have been withdrawal, helplessness, expectations of failure, oral aggressive and sadistic fantasies, thoughts of death and death wishes towards her maternal grandmother and mother and great fear of her anger. There was an inability to demand, later followed by greedy wishes to get everything, overt rivalry with older and younger siblings, and later with peers and other patients whom I see. Finally, she reached a stage of object constancy with the therapist and with her father more than her mother which could be verbalized on her part. Currently she is approaching the oedipal resolution, wishing to be the queen in her

school play and to sit on the stage the entire time. She draws pictures of her parents with her father as an indian, always "smiling" and her mother as an indian "often angry." Eating has never been a problem since I have known her. Enuresis and constipation stopped when her mother left a light on in the bathroom for her. It is apparent that at this stage she is ambitious and very envious of boys, much as her mother is ambitious and envious of men. Neither can tolerate entirely their open angry feelings.

To me it is most interesting that after 16 months of thyroid supplement, growth rate per month in height and weight were only slightly increased. After six months of therapy, however, the height and weight rates per month doubled. She is told currently that if she continues to grow at this rate, she will be of normal size at ten years.

Her mother is an intelligent and very compulsive woman, the only member of her family able to move away from her own very rigid, domineering mother. Laurie's mother equated her with her own older sister, the second in her family, who at the age of 34 has never dated or left home. Laurie's mother expresses extreme disinterest in this sister behind which is real hatred and jealousy. She has "expected" Laurie to fail in many enterprises as her sister did. She also often places Laurie last in the family concerns. For example, she is unbelievably stingy with Laurie. Until January 1970 mother kept the crib sides on Laurie's bed which had been totally unnecessary. Mother was very guilty about Laurie in therapy and about her anger towards Laurie, but this is much better with treatment and with Laurie's growth and successes. I find it very interesting that the mother's oldest brother also has a second child, a boy, with severe growth failure and many symptoms like Laurie's.

Diagnostically, Laurie qualifies under eight of the nine categories given by Sandler and Joffe. Only in the category of oral passivity this is not true; instead one sees oral aggressivity in the screaming, the voluntary regurgitation and in her first drawings for me.

Case Summary—*Lisa*

My second case is Lisa, age four and a half, black and living with 16 other people in a house headed by a blind grandmother. Lisa seldom speaks. She is a large, sad, withdrawn girl constantly sucking her thumb, who does not try anything new and at times retreats entirely when urged to try something new. Very occasionally she fights briefly but violently. With any change of scene, such as the class going outdoors, she clings to the teacher and cries. After my first visit, with her, she cried for her "mama" when I left. Outdoors she does not play but eats sand unless restrained. She is not curious and cannot organize her play in terms of new sequences nor does she seem to even anticipate pleasure from play. One might feel that she

is retarded except that after several of my visits, often interrupted by a hyperactive cousin, she was able to move towards a truly more creative way of playing with the objects we had. I only go every two weeks to her home, but she always greets me when I appear and then clings to me. At the Christmas party she could not sing Jingle Bells with the others although she knew it well, but she went often to get more gifts without opening those she had.

Home life is that of the truly disadvantaged—no mother or father since birth, many inconsistent mothering figures to whom she is a burden as well as a pleasure, no consistent place to sleep. All her efforts to imitate older people are discouraged and she is ignored or smacked. There have been few consistent emotional interchanges between mothering figures and this child, which according to Dr. Spitz are the precursors of the verbal dialogue. He feels that by the end of the first year the child shows imitation and identification with its parents in the never ending minutia of these exchanges. One has only to see the movie by Sylvia Brody and Axelrad to recognize this and what it does for a child's development. Lisa, to whom this chance to imitate is often absent, shows incomplete ego formation and incomplete infantile clinging relationships with any possible love object. She also often shows an inability to perceive or learn as a result. Dr. Metcalf in Colorado has shown that as early as the neonatal period the mother-infant interaction influences the infant's neonatal sleep as measured by the EEG. I have suspected this since my colic studies 17 years ago.

Lisa, as well as Laurie, is a depressed child; but the difference is that she has never had a love object so never really lost one as Laurie "lost" her mother first to her brother and then to her mother's depression. Laurie showed the affective expression of a state of helplessness and powerlessness due to the superego-ego conflict which prevented her from directly expressing her ambivalent anger at her mother for her brother's birth and mother's depressive withdrawal. Bibring (1951) states that it is exactly from this tension between such a wish to be good and loving and not aggressive and hateful that depression results. Lisa, on the other hand, has retreated to helplessness and possibly hopelessness because each phase of development of her ego has been curtailed or disparaged by those around her.

Summary

However the argument about diagnosis of depression in childhood is resolved, there is much for the child psychiatrist to learn from these two cases. While Laurie's emotionality was recognized, nothing beyond the use of tranquilizers was done about—probably because no child psychiatrist was available in Williamsburg. There is still feeling on the part of some doctors that Laurie's growth failure is entirely a medical illness;

so we have education to carry on with fellow physicians. More important to me, I see from the second case a new task for the child psychiatrist—working out plans that will make the early years of life for a child like Lisa, especially the first two years until speech has developed, richly rewarding for her development in terms of daily experiences with a mother who is able to invest herself appropriately in mutual inter-exchange. Mothers of disadvantaged children are seldom able to offer their child what they did not have themselves, and any such programs for the child must include simultaneous though different programs for the mother. It is my opinion and that of others, including Dr. Maria Piers at the Ericson Institute in Chicago and Dr. Lois Murphy who I heard recently with Dr. Spitz and Dr. Reginald Lourie in Washington, that in many ways massive programs must be devised to eradicate the development of depressed, disadvantaged children. We should have learned our lessons from the orphanage and the Kibbutzim which made it clear that food and housing are not enough to prevent the repetition with each generation of depressed unstable individuals who, like Lisa, have difficulty learning and will repeat the generational cycle of the disadvantaged.

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Book Review

Ocular Syndromes. Walter J. Geeraets, 2nd Ed. Philadelphia: Lea Febiger, 1969. 289 pp. \$9.50.

Size is no indication of quality in medical books. This small volume is amazingly informative. Structurally, it is an ingenious cross reference analysis of syndromes which have ocular signs as primary, secondary or rare manifestations. Initially, syndromes and their synonyms are listed in alphabetical order. Although the extensive use of eponyms may lack appeal to some, it is simpler to remember "Ehlers-Danlos" than the less conventional synonym Fibrodysplasia elastica generalisata. In the next section, the 197 syndromes which have ocular manifestations are described. Not only are the findings in each portion of the orbital apparatus (lids, extraocular muscles, lacrimal glands, visual fields, anterior chambers, sclera, media, retina, choroid and optic nerve) clearly delineated, but concise, pertinent general information and other findings of clinical consequence are also presented. The bibliography is particularly well selected from original, classical descriptions, reviews and recent contributions.

Remaining cross reference sections make this monograph unique. Each portion of the ocular apparatus is listed together with the syndromes which may affect that portion and the manner of affliction. Each organ system is similarly outlined with a complete list of syndromes affecting that system and the orbital contents. Finally, syndromes are placed in categories based on age, sex, hereditary and etiologic factors.

Although this book is apparently a necessity for disciples of ophthalmology and neurology, it is not initially apparent that other practitioners would find it useful. Because many of the syndromes described (Rubella, Down's, Crouzon, de Lange, Ehlers-Danlos) are manifested at a young age or associated with congenital abnormalities, geneticists and pediatricians would find it of interest. Internal Medicine, so diverse in its scope, will readily appreciate the efforts of Dr. Geeraets in summarizing such a quantity of information. Over the period of a few months this book was used in following a number of patients on a general medical service. The syndromes (diseases) encountered for which *Ocular Syndromes* proved to be of value in learning and teaching included: amaurosis fugax, Argyll Robertson, Cushing's, Down's, Sickle Cell Anemia, Guillain-Barré, Horner's, Marfan's, Parinaud's, Sarcoidosis, Sjogren, Stevens-Johnson, Pseudo-xanthoma elasticum, Werner's and Wernicke's. For the student and resident this handy book was of continued value in expanding on previously acquired

knowledge and attempting to correlate and understand the complete spectrum of disease presented by the patient. Its greatest value to the young physician will be as a reference book on the ward to supplement and correlate information.

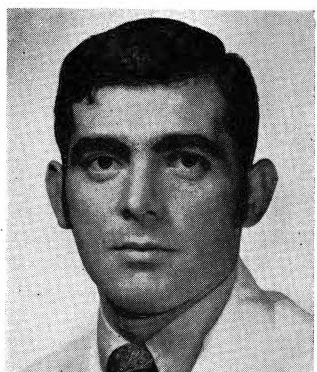
The author has fulfilled his declared intentions, tabulating and cross indexing syndromes associated with ocular manifestations in a pocket sized edition for daily clinical use. Its primary value will be to specialists, house officers and students. Wording is succinct by nature of the objectives of this book.

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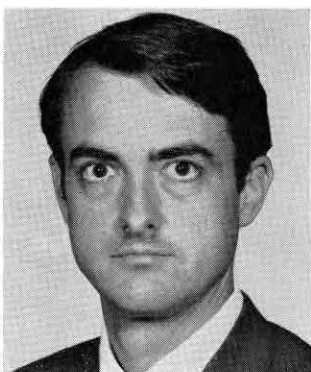


Contributors

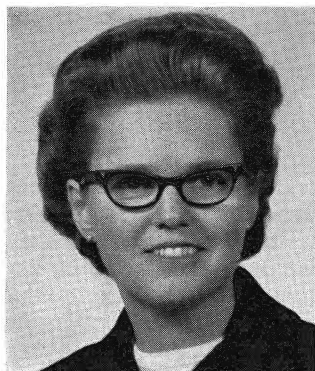
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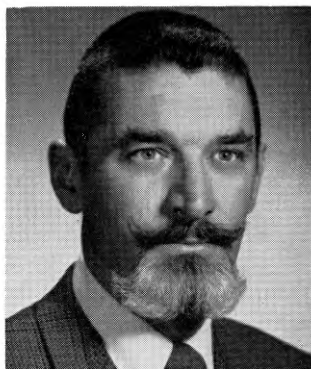
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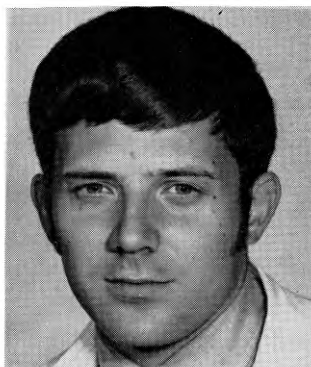
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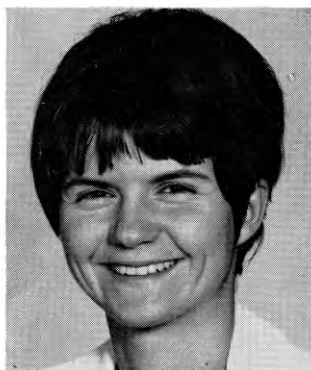
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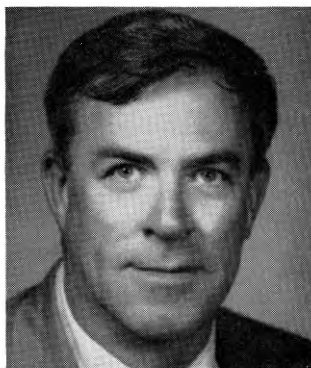
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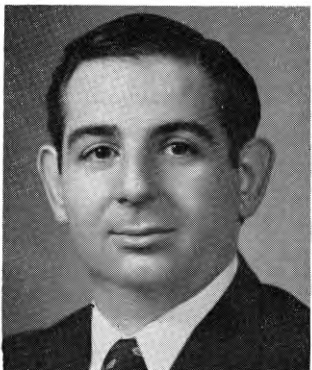
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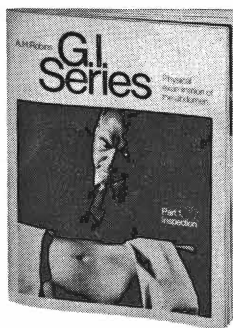
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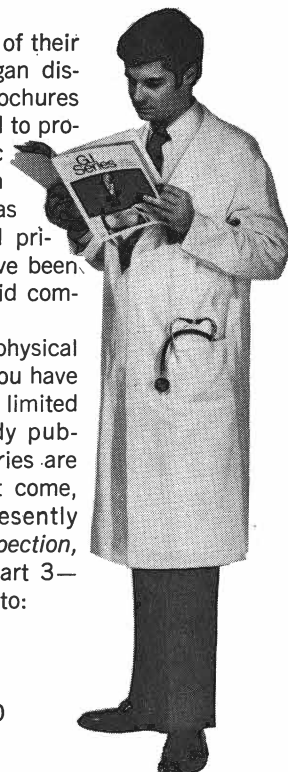
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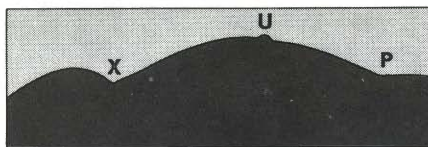
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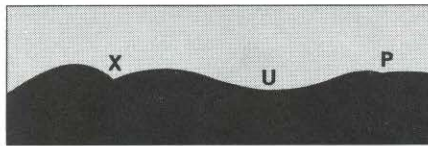
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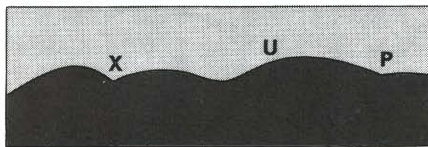
generalized distention, with umbilicus inverted: obesity or recent distention from gas, etc.



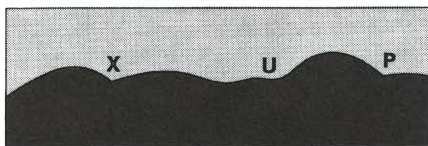
generalized distention, with umbilicus everted: chronic ascites, tumor, or umbilical hernia



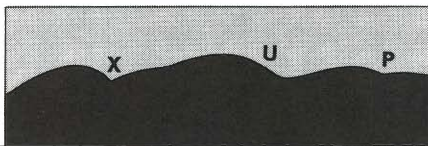
scaphoid abdomen, from malnourishment



distention of lower half: ovarian tumor, pregnancy, bladder



distention of lower third: ovarian tumor, uterine fibroids, pregnancy, bladder



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