American Handbook of Psychiatry

PSYCHOLOGICAL DISORDERS of the GRADE SCHOOL YEARS

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PSYCHOLOGICAL DISORDERS OF THE GRADE SCHOOL YEARS

Since the last edition of the *American Handbook of Psychiatry* was published, the confluence of a number of trends has brought changes in the course and evolution of child psychiatric activities that we did not clearly foresee a decade ago. The effective treatment of neurotic children has led to the demand that we similarly treat children with other disturbances and that we care for many, rather than a modest number of, boys and girls. The mental health outreach into poverty areas brought the role of cultural deprivation and racial discrimination into our work with inner-city children and involved us with a larger number of children showing developmental arrests and deviations. When education became imperative in a technological society, our clinics received more referrals of children with serious learning disorders and perceptual handicaps. A growing emphasis in theoretical discussions on the role of interpersonal relations in mental health and illness of children placed a focus on the importance of object relations and object loss in a child's growth and development. Medical advances made it possible for children with serious congenital handicaps to survive and to present later problems in personality organization, learning, and behavior. The increasing societal pressures to which all of us are vulnerable have put a premium on the issues of self-esteem, flexibility, and adaptation to change. All these trends contributed to the changing character of the caseloads in our clinics and in

our consultation work, namely, a larger number of children with developmental deviations, minimal brain damage, and personality disorders. They drew attention inevitably to the status of our nosology and pressed us to refine our classifications so that our work could be based more securely on a psychological understanding of the child and his milieu.

As the community mental health movement gained momentum during the 1960's, demands for children's services led to the creation of a blueprint, a comprehensive range of services for children from birth to adulthood, from all socioeconomic and racial groups, with varying modalities to carry out prevention and treatment efforts for all types of emotional disturbances. Though few programs have as yet been funded and staffed sufficiently well to replicate such an ambitious model, most child psychiatric facilities have moved toward the blueprint, providing a greater variety of services for a wider range of children. Programs of education for paraprofessional and indigenous workers and in-service training of personnel for specialized but limited skills proliferate to try to solve the pressing personnel problems.

These institutional changes highlighted the shortcomings of all nosological schemata of the emotional and personality disorders of children. In discussions of the Joint Commission on the Mental Health of Children, the criticisms varied with the orientation and responsibilities of the speakers, but the need for feasible schemata for all child mental health activities was

generally accepted.

In his chapter on "Common Neuroses of Childhood" in the first edition of Volume I of the *American Handbook of Psychiatry,* Cramer referred to the difficulties in constructing a classification of children's emotional problems and concluded, "it is probably not possible clearly to delineate one." However, because of all the changes and trends outlined above, we in the profession have been forced to give our attention to nosological schemata and to make determined efforts to devise more satisfactory classifications.

We remember vividly an experience over fifteen years ago when we were involved in consultations about diagnostic studies in a state youth service facility. Three fifteen-year- old youths were committed for the identical crime, namely, stealing an automobile. Our diagnostic studies revealed that one boy was floridly schizophrenic, another a young person whose life pattern of impulsive, disruptive, and antisocial behavior had begun before his school years and had continued uninterruptedly, and the third boy was caught up in an intense neurotic guilt reaction related to his unhappiness over his relationship with a recently widowed mother. Each of these boys obviously required a different plan if more than custodial aims were to be met by his commitment to the youth services.

Child-care agencies, community mental health programs, and child

psychiatric facilities alike need to incorporate within their operations some systematic sorting out process that offers guidance, however imperfect and incomplete, in setting up management plans and provides some useful prognostications about children and adolescents. The evolution of family diagnosis and therapy and the model of treating the family may create even more confusion if little attention is paid to the specific elements of the child's disturbance and to his special needs.

The problems of constructing a satisfactory classification of children's emotional disorders are great, the reason undoubtedly that all attempts thus far have met with serious criticisms. The very nature of childhood and of the many factors that can influence a child's growth and development positively or negatively create a large number of variables, with interrelationships extremely difficult to formulate. Nonetheless, during the years since the first edition of the *American Handbook of Psychiatry* was published, we have witnessed significant progress in grasping the intricacies of the classification process and in bringing to diagnostic thinking concepts of considerable value for assessment and management planning.

The 1966 Group for the Advancement of Psychiatry (GAP) report on psychopathological disorders in childhood represents the most ambitious and effective attempt thus far to provide a nosology bringing together psychosomatic, developmental, and psychosocial propositions in positing

major categories of childhood disturbances. The report was the culmination of work begun by members of previous committees on child psychiatry, and in it the 1966 committee succeeded in preparing a synthesis of conceptualizations and clinical experiences more nearly adequate to our evaluative needs than any previously constructed. The committee took as its point of departure the nature of twentieth-century scientific thinking, which "strives to be multidimensional, relativistic and dynamic in character, relying on probabilities rather than certainties." They formulated:

> a conceptual framework that would encompass the characteristics of personality formation and development in childhood in sufficiently comprehensive fashion to permit professional people from differing schools of thought to agree at least upon a point of departure to a classification of disturbances and deviations. The influence of hereditary factors, the impact of familial and other environmental influences, the significance of developmental capacities and vulnerabilities, the fluidity and plasticity of the young child's personality characteristics, and other considerations obviously had to be taken into account. In addition, the tendency of the clinician to see and classify pathology rather than health was recognized. Accordingly, the conceptual scheme evolved must permit in some measure an understanding and classification of healthy as well as unhealthy reactions and behaviors. Above all such a conceptual framework must be clinically relevant if it is to be at all helpful in undergirding a classification constructed for everyday clinical usage.
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> In searching for a theoretical framework that would meet the various tests it must survive, the Committee felt that three basic propositions were vital: (a) the psychosomatic concept, involving the unity of mind and body and the inter-related- ness between psychological and somatic processes; (b) the developmental dimension, so central to the study of the child; and (c) the psychosocial aspects of the child's existence in the family and society.

The following major categories are proposed:

1. Healthy responses
2. Reactive disorders
3. Developmental deviations
4. Psychoneurotic disorders
5. Personality disorders
6. Psychotic disorders
7. Psychophysiologic disorders
8. Brain syndromes
9. Mental retardation
10. Other disorders.

Each major category is broken down into subcategories, and a symptom list encourages further specificity in assigning a diagnostic formulation to an individual child.

Specific aspects or isolated items of this schema may be criticized; perhaps its most important weakness lies in conceptualizations of disorders in which social and cultural factors play a predominant role. In a paper for the Clinical Committee of the Joint Committee, the chairman of the GAP Child Psychiatry Committee, Dane Prugh, tried to deal more fully with the psychosocial dimension. Whatever flaws the report presents, it is an effort at once practical and creative in a field to which many experienced clinicians

have contributed without producing an end result as effective as this classification schema.

The GAP report reflects the influence of important bodies of clinical work and theoretical considerations which encourage a more sophisticated level of diagnostic thinking and more precise treatment planning. It is difficult to estimate the influence of Anna Freud's concepts of developmental lines, the end product of the research of her child psychoanalytic group at Hampstead, England. The group proposed a complex diagnostic profile through which a child's development could be traced, indicating the evolution of energies, defenses, traits, relations to others, modes of behavior, and adaptation over a period of years. The process clearly rests on a very detailed clinical history taking, and a mastery of the underlying principles requires intense study and developmental sophistication. Despite the fact that the profile is attuned to the collection of data through the psychoanalytic method, the concepts of the developmental lines are being applied to historical and cross-sectional data accumulated through other techniques.

A. Freud's 1970 preliminary classification of the symptomatology of childhood demonstrated a continuing thrust of the Hampstead clinical research into the areas of assessment of children not treated by the psychoanalytic method. Her concluding comment contains the thesis of this chapter, namely, "it is reasonable to expect that any step forward in the

refinement of diagnostic assessment will, in the long run, lead to improvements in matching disorders and therapy in the children's field."

Erikson's concepts of psychosocial maturation according to epigenetic principles continue to provide guidance to the diagnostic thinking of many child clinicians who decry the inner directedness of psychoanalytic schemata but find the usual symptomatic rubrics too slight for the assessment task to be done. However, Dane Prugh illustrated how far- reaching Erikson's psychosocial schema actually is:

In Erikson's "house of many mansions" we can thus fit various types of learning theory including operant conditioning; Piaget's and other concepts regarding intellectual development; cybernetic theory; small group and family theory; sociocultural theories; field theory; systems theory and communication theory, not to mention the more classical theory of psychosexual development derived from Sigmund Freud and Anna Freud's recent elaboration of "developmental lines."

Certain themes relevant to understanding childhood emotional disturbances appear and reappear in the literature. Though neither the supporting work nor the concepts first appeared during the last decade or so, they have nonetheless lately received emphasis and elaboration so that they strongly influence diagnostic and therapeutic thinking.

One of these themes is the focus on constitutional and/or congenital deficits which limit and distort the child's developmental capacities from birth on and strongly influence the responses and behaviors of caretakers. Studies of the congenitally blind child (Fraiberg), many papers concerning the minimal brain damage syndrome, and studies of children with other serious physical handicaps reflect the growing appreciation of the influence of such conditions on personality organization and parental response to the child, and provide cues for more effective management when such children are brought to the child psychiatrist.

A second theme that strongly influences diagnostic thinking and hence treatment planning is that of object relations and object loss. We are indebted to the Kleinian group of English analysts for studies and formulations that centered our attention on the crucial roles of the child's objects and their images in his inner life. Fairbairn's writing on object relations and their key place in personality development and organization and Bowlby's work on early maternal deprivation promoted the search for ways of understanding human relatedness and its vicissitudes. The other side of object relations, the loss of the object, again is not new to our theorizing about personality development and child psychopathology; however, the emphasis given to it by Rochlin underlined the ubiquitous character of loss, the constant fear of it, and the crucial power of these to shape character and future experiences.

The issue of object relations and object loss appears to be one of the most cogent and useful considerations in viewing the natural history of a child's emotional disturbance and in setting up what needs to be done to free the progressive developmental forces for the child's growth and maturation. The child's actual experiences of loss, when they occurred, the support available to him, and the manner in which he could cope with the loss are definitive in determining the degree of his vulnerability to future stress and the quality of the resources he can muster to master a real or fantasied recapitulation. New developmental challenges or life's vicissitudes have a way of probing the weaknesses in trust and self-esteem that previous experience of loss can engender; the more global defenses available to counter massive anxiety and rage at an early age may need to be remobilized when later traumata or extreme stress break through the current adaptive equilibrium. In addition, each developmental step carries with it the abdication of prior gratification and the giving up of previous modes of behavior; along with the gains of mastery and a new level of adaptation go the losses of parts of the past. Loss as well as gain is an inevitable component of change and adaptation.

Mahler intensively studied the nature and significance of the period of separation-individuation during infancy, and her concepts have value for identifying basic difficulties and for tracing the vicissitudes of effective or faulty adaptations to the developmental task of self-other differentiation.

Still another theme frequently used for its diagnostic and explanatory value is that of the need of the infant and young child for an optimal degree, kind, and variety of stimulation and interaction with his caretakers. There are many controversies about whether certain inner-city children have too much or too little stimulation. The issue probably is more wisely phrased in terms of the child's relationship to the one stimulating him, his preferred sensory modalities, and the timing, intensity, or nature of the stimulation.

The concept of adaptation plays a larger role in diagnostic thinking about childhood emotional disorders since the developmental point of view and the teachings of psychoanalytic ego psychology became more widely used by clinicians. This issue was dealt with at some length in the report of the Clinical Committee for the Joint Commission:

> Concepts of health and illness or of function and dysfunction in children differ somewhat from those applicable to adults, depending upon the child's capacities at a particular stage of development, the current nature of the family transactional operations, and other factors. Nevertheless, the concept of adaptation to the environment (or of effective coping, mastery or psychosocial functioning) is central in relation to both children and adults. In the modern unitary theory of health and illness, health and disease are considered phases of life. Health represents the phase of positive adaptation by the human organism, and in the child, the phase of growth and development. In this phase, the child is able to master his environment and himself, within stage-appropriate limits, to learn effectively, and is reasonably free from pain, disability or limitations in social capacities. Illness or dysfunction represents the phase of failure in adaptation or of breakdown in the attempts of the organism to maintain an adaptive equilibrium or the dynamic steady state (at any one moment in

the forward development of the particular child).

These themes and concepts have played their part in the growing tendency to use the developmental point of view in clinical assessment and management planning. The developmental approach to the evaluation of children's emotional difficulties and to the planning for their amelioration offers the clinician many advantages. He is oriented to a point of view that postulates a series of developmental stages during the course of which the child's constitutional givens interact with his experiences to the end of mastering psycho- biological tasks and adapting to the demands of growth and maturation in ways acceptable to his society. The clinician looks, therefore, for information about the child's makeup and his health; he looks for data bearing on the effectiveness and the fit of the way the child was raised by his parents or their surrogates. He wants to know how the child met traumatic situations and adapted to such normal but often taxing events as the birth of a sibling, change of domicile, and leaving home to enter school. He assesses whether the child experienced the support of his milieu as predominantly positive and helpful or whether he lacked trust and confidence. The clinician tries to discover what the child's coping modes are and under what circumstances he is able to use them; he wants to know of the people and the structures in the child's life that promote or could promote his growth and maturation. Within such a context, he studies the child's symptoms, their history and course, and he is alerted to evidence of earlier,

even if transient, childhood disturbances which left vulnerabilities in the child's capacities for object relating, tolerating frustration, mastering anxieties, and reality testing. The clinician looks for data bearing on the points of great inner stress and tries to follow the vicissitudes of the child's handling of sexual and aggressive impulses.

The growth process hence becomes the central focus, and the child's symptomatology is viewed as a manifestation of disruptions in it.

Groupings of Children's Emotional Disturbances

It is in line with such reasoning that we describe below groupings of children's emotional disturbances and present suggestions for therapeutic management. It is obvious that in the space of this brief review we cannot list and discuss all the disorders considered in the GAP report, the American Psychiatric Association diagnostic classification 2, or other nosological outlines in use. The following are groupings of children we find coming frequently to our attention in today's more comprehensive programs and/or presenting evaluation problems often interfering with their effective management.

Physiologically Based Disturbances

The first grouping we wish to discuss is that of children with a major

disturbance in the early years owing to constitutional defect, congenital handicaps, or serious ailment during infancy. Our knowledge of the influence of these disabilities on cognitive development and personality organization is still fragmentary, but clinical research studies and experiences with individual children are filling in some of the gaps. It is clear that such conditions alter and distort the course of the child's progression, but it seems also that the extent of the developmental deviation depends a great deal on the feedback from the baby's surroundings, whether positive or negative, and to what degree. Children with a major sensory defect, such as congenital blindness or deafness, show marked but differing developmental deviations. Selma Fraiberg has illustrated how certain blind babies escape the arrest in growth pattern, the passivity, lack of motoric achievement, and limited relatedness to people characteristic of many blind infants; they were encouraged by mothers (and fathers) who could help them relate to others and find a different but an effective route toward personality organization. From such parents and babies Fraiberg's group learned how to teach other parents to provide the positive feedbacks that enabled their infants to progress. Such infant studies open up a whole new area of intervention in infants with a variety of serious physical conditions hindering the usual growth process.

Those disturbances of growth and development secondary to central nervous system deficits appear to be occurring more frequently. The physical

disabilities of cerebral palsy are often accompanied by distortions, irregularities, or failures in different development lines, the most common of which is mental retardation.

The syndrome called most often minimal brain damage is highly controversial, but children displaying the symptoms of hyperkinesis, distractibility, impulsivity, and difficulties in learning are generally considered to suffer from cerebral cortical damage of a diffuse nature. It is these children who respond well in a high proportion of instances to the amphetamines. They show diffuse abnormalities in the electroencephalogram and in electromyography. Their difficulties in learning to read and write and in developing abstract concepts are associated with difficulties in perceptual motor functions, spatial orientation, and cerebral integration or organizational capacities. Specific neurological lesions are rarely found, and the diagnosis must usually be made on history and the above symptomatology. Recent studies indicate that though the hyperkinesis often abates during adolescence, the defects in learning capacities, social adaptation, frustration tolerance, and other basic ego functions persist.

The evaluation of the developmental status and level of functioning of a child with a major sensory or central nervous system handicap or other major physical impairment requires a synthesis of information from neurologists, educators, pediatricians, and other specialists with the history given by the

parents and the assessment of child and family by the child psychiatrist at the time of referral. However, a careful psychological evaluation may be minimized in the study of the many dimensions to be assessed in a child with severe epilepsy, cerebral palsy, serious birth defects, club feet, or cleft palate. Nonetheless, there are certain key psychological issues that require attention and must be the focus of management planning from the standpoint of personality growth and development. The first is the profound effect of such disabilities and defects on the self-esteem of the child. The vulnerability of his sense of self and self-worth may lead to an exaggeration of the significance of a defect, for instance, a convulsive disorder or a cleft palate, so that the child's self-image is that of one generally and severely defective or hopelessly inadequate. Such a self-image will interfere with the thrust of progressive development and may make all efforts at education of the child very disappointing. The second point is the role of the child's guilt, which may be overlooked in the perception of the family's complicated ways of dealing with its own ubiquitous feelings of guilt. The child must deal with the hostility he feels because of his condition; increased aggressive impulses may be mobilized by the physical care of his handicap, for instance, immobilization in a plastic cast, painful operative procedures, hospitalizations, medications, and restriction of activity. If the child internalizes his hostility, he suffers from a heavy load of guilt which interferes with his relationships with people and with his achieving and predisposes him for masochistic destructive character

formation. If he has to project his feeling of hostility, a greater or lesser degree of paranoid thinking and behavior will color his reactions and interactions. The latter occurs frequently in juvenile diabetics.

The management of these handicapped children depends on a skillful synthesis of the evaluations of their total potential for growth and the coordination of efforts of several specialists from different disciplines to promote the child's development. Psychoeducation, psychotherapy, drug treatment, and parental counseling may be needed concomitantly, intermittently, or sequentially for longer or shorter periods. These various treatments may be indicated particularly at such times when maturational and developmental milestones tend to create additional stress situations for these children (for example, during the early school years, on entering puberty, and in the course of adolescence).

Developmental Irregularities or Failures

The grouping of developmental irregularities or failures is a far more significant sector of childhood emotional disorders than we have realized and one about which we have somewhat more understanding today than we had a decade ago. The work of the Hampstead Clinic, studies of psychotic children, the experiences of our colleagues in psychoeducation, and clinical contacts with culturally deprived children have demonstrated to us that in certain

children, specific ego functions have not developed or developed more slowly or faster than others, or developed only partially, leading to a wide range of symptoms. The model of childhood neurosis on which the concepts of child psychotherapy were built does not apply directly to these children, and there is no doubt but that many of our failures in management have come because we have assumed that we were treating neurotic children whose achievements had been lost or undone through regression. The distinction is an important one to make, since quite different therapeutic approaches may be needed to ameliorate a developmental failure from those useful for a child in a neurotic regressive state. It is, however, a differentiation that may be confusing and difficult to make. Our need for more careful and systematic clinical research is obvious.

A child's failure to reach the expected level of growth may show up anywhere within the structure of his personality. It may concern the milestones of his first year, it may involve a lagging in drive development or in a wide variety of ego functions, it may appear in superego formation. Anna Freud wrote,

Developmental irregularities and failures confront the clinician with many problems, foremost among them the need to differentiate between the causes for them. Retardation of milestones in the first year of life raises the suspicion of organic damage. Delay in drive development may either be due

to constitutional factors or may be determined environmentally by inadequate response from the parental objects. Ego retardation is frequently due to poor endowment, but, as the study of many underprivileged children has revealed, equally often the consequence of lack of proper environmental stimulation. Arrested superego development may be part of general ego retardation and share its causation or it may be due to the lack of adequate objects in the child's environment or to separation from them; or to internal failure to form relations to other objects; or to the qualities of the parental personalities with whom the child identifies. Traumatic experience may at any time endanger progress in any direction or, at worst, bring forward development to a standstill.

A. Freud agrees to the difficulties in distinguishing between these types of damages to development and those that represent the undoing of developmental achievements after they have been acquired and which are due to regressions and inhibitions based on conflict.

> The most reliable hallmarks of neurosis are anxiety, guilt and conflict while in contrast to these, the various types of developmental arrest may remain internally undisputed, especially in those cases where the arrest affects more than one sector of the personality. But this diagnostic indicator too cannot be trusted in all instances.

The management of developmental irregularities and failures is best effected by variants of educational methods directed at the promotion of the

functions that have been arrested or distorted. Psychoeducational programs, behavioral modification techniques, and group therapy with a heavy emphasis on ego training are among the most effective modes presently employed. Whatever modality is chosen, the issue of relatedness to the teacher, clinician, or therapist is of primary importance. We learned years ago in the pioneer work with psychotic young children that ego growth, ego synthesis, and integration can be promoted only in the setting of an object relation; this lesson holds for children whose developmental failures are based on less overwhelming traumatic experiences or failures to thrive.

Psychoneuroses of Childhood

The psychoneuroses of childhood, the most familiar category of the diagnoses associated with psychoanalytic concepts and dynamic psychiatry, are among the more controversial today. Of course, the model was derived from the psychoanalysis of adults; as more sophistication in determining developmental stages and particularly the development of various ego functions emerged, it was observed that these stages of development and functions of the ego did not always mature in unison; hence a more frequent difficulty in using the adult diagnoses arose. It became apparent that full-blown psychoneurotic syndromes did not appear as often in childhood as in later life and that this finding was to be expected.

The obsessive-compulsive neurosis in children resembles more closely the adult picture, and there is little disagreement about these cases.

The picture of a hysterical psychoneurosis in a child appears more severe than its adult counterpart, and on examination, the child usually presents an hysterical character with many pregenital features, especially of an oral nature. The more transient reversible neurotic behaviors no longer are commonly seen in child psychiatric clinics, since pediatricians, school counselors, or social workers are more likely to deal with them than psychiatrists.

The very nature of childhood complicates the process of diagnosis and nowhere more clearly than in the category of the psychoneuroses. The very same factors, however, contribute to a fluidity and a potential for change that can alter the psychopathological state and the developmental stasis in a fashion that would be astonishing in an adult. Our management measures and prognostications need to reflect the range of possibilities for change that development and life events can bring about.

The disorders in the oedipal period present some of the most clear-cut examples of psychoneuroses seen in children. The struggles of the young child to maintain his psychic equilibrium in the face of conflicting wishes to win the favor of one parent while vanquishing the other, both of whom he

needs and cherishes, precede the thrust of active exploration of the outside world which entering first grade provides. His conflicts in this triangular situation in which both sexual and aggressive impulses are invested are unconscious, and the pursuant anxiety leads to a number of defensive operations and symptoms that characterize the neurotic picture. Little Hans is the classical example in the psychoanalytic literature of a neurotic youngster of this age; his phobias, his behavior toward his parents, and his shifting explanations of his difficulties illustrate his preoccupations with his parents and the resulting picture when the boy could not handle his conflicting needs, wishes, and fears.

Psychoneuroses are based on unconscious conflicts over the handling of sexual and aggressive impulses, which though removed from awareness through the mechanism of repression in combination with a number of other defenses, such as denial and displacement, remain active and unresolved. Though conflicts may begin and remain to some degree active during the preschool years, the life situation triggering a neurotic formation is the child's sharp conflict in the triangular position with his parents. His sexual and aggressive wishes toward them become unbearable, and he develops symptoms of anxiety, regression, phobias, physical complaints, and so on. If the child cannot resolve his conflicts and renounce his wishes as the developmental progression provides him with more flexible and effective defenses, his conflicts about and with his parents become internalized and

tend to assume a chronic character. Modifications can occur with development; environmental change and manipulation can influence the symptomatology, but the more usual natural history demonstrates a self-perpetuating or repetitive nature. The neurotic difficulties usually manifest themselves in an interference with an important object relationship, the child's own feelings and wishes become incongruent with the expectations of parent or sibling and later with the child's own inner standards of acceptability. The resulting ambivalences toward parent or sibling figures are readily transferred in school or play to teachers and playmates who are invested with strong emotions and fantasies displaced from the actual situation and original cast of characters. In other children the ambivalences hold them fast to the family and prevent the child's moving toward new objects.

Much energy can be spent on futile discussions of whether a child's conflicts existed before the oedipal period or rather arose only at that time. Problems during early childhood can provide fertile soil for intensified conflict, symptom formation, and defense evoked by the oedipal struggles.

Neurotic children usually relate well to a clinician; there is a history of developmental achievements and of positive attitudes toward neighbors, friends, or teachers which contrast with the dismal history that may accompany more disturbed children. This contrast leads some mental health

professionals to minimize the needs of the neurotic child for specific treatment because “he isn’t as sick as the others, and they need it more” (for instance, the disorganized, borderline, or psychotic child) and because they expect that “he will grow out of” his disability.

There is a related belief that poor and minority group children do not suffer from psychoneuroses and that only middle- or upper- class boys and girls do so. Though it is probably true that the proportions vary in the two populations it is likely that there are many more instances of psychoneuroses in the inner- city population than are correctly diagnosed in busy mental health facilities.

The clinical judgment that neurotic children are less sick and so deserve less attention leaves out of consideration several significant factors: (1) the constricting and warping influence of unresolved neurotic conflicts on personality and character formation; (2) the necessity for appropriate treatment if more than transient symptom relief is to be attained; and (3) the potential of these children for optimal self-realization and contributions to our society if their capacities can be freed for growth and progression.

Two eventualities are observed repeatedly in families studied in clinics, and each illustrates the burden of unresolved childhood neuroses extending into adult life and distorting adult functioning, namely, chronic

underachievement in work, in love, and in play and an often painful interference with parental functioning.

As mentioned earlier, the older divisions of the neuroses of childhood and youth into the hysterias and the obsessive-compulsive neuroses have recently met with dissatisfaction. The latter condition is one most observers describe in a similar fashion: The anxieties produced by unconscious conflict and involving particularly aggressive impulses and wishes are defended against and defused by a preoccupation with stereotyped acts or rituals also serving the purpose of binding anxieties. The nuclear conflict from which the child regresses is that engendered by the triangular situation with the wishes toward the' parent of the opposite sex poised against those of an aggressive nature toward the parent of the same sex. The neurotic child does not know why he pursues these thoughts or acts, but failure to think such aggressive thoughts brings on such anxiety that it is difficult indeed to persuade him to refrain from them long enough to discover their links to charged affects and memories. Obsessional children are often highly intellectual, deeply interested in acquiring facts, valuing knowledge, and isolating from their awareness feelings or the memories of fantasies and emotions. They rely heavily on denying their aggressive thoughts and impulses, persuading themselves of holding precisely the opposite sentiments: These reaction formations protect them from a guilty awareness of their hostile and cruel impulses. Their internalized standards are very strict and can lead to a

progressive restriction as the child struggles to defuse the dangerous impulses and take distance from them. A strong belief in magic pervades the obsessional child's attitude toward the world, and words are especially invested with power, being equated with acts. As we learn more of such a child, we are likely to find that his relations with people at one point were less ambivalent and less polarized between love and hate, and we can find evidence that the triangular relationship with his parents was a highly stressful one for him. The nature of the obsessional's preoccupations and of his object relations suggests a regression to anal-retentive modes with the sadistic coloring often characteristic of fantasies and impulses of this developmental level.

Current doubts about an entity of hysterical psychoneurosis are illustrated by the omission of this diagnosis in the GAP report. There is a rubric of hysterical personality disorder, but the section on the psychoneuroses lists in addition to the obsessional neurosis the following: psychoneurosis anxiety type, phobic type, conversion type, dissociative type, and depressive type. The likelihood is that many clinicians would place the children that the GAP report describes in these subcategories into the group of hysterical psychoneurosis. These children are apt to be lively, warm, perhaps seductive, and rather charmingly immature. They cling in a coy manner to important objects and give the impression of accomplishing less than they are capable of. Their ways of relating and behaving are often highly

eroticized, and therapy with them may become stalemated on this issue. Often they come to our attention because of a physical complaint "for which no organic cause has been found," and their attitude toward a serious dysfunction is one of apparent indifference unless or until therapeutic work with them begins to disturb their defensive facade.

The immature and dependent stance of these children coupled with considerable oral preoccupation leads the unwary to assume the child's psychopathology is centered at an earlier level than that of the oedipal struggles. Their easy regression and preference for this mode of combatting anxiety can be problems in therapy as well as diagnosis. Careful history taking reveals that the child has mastered relatively well the various developmental tasks, but at the time of referral is functioning less maturely than that history would lead one to expect. Phobias of a fleeting or more lasting nature, nightmares, temper tantrums, and impulsiveness are reported. Particularly common is underachieving in school.

In some children, overt anxiety is such a prominent symptom that anxiety hysteria or anxiety neurosis is the diagnostic label applied. The impression one receives is that the defenses of repression, denial, and regression were not sufficient to contain the anxiety engendered by the conflicts over sexual and aggressive impulses. Though phobias are the example par excellence of the neuroses of early childhood, grade school

children may demonstrate this symptom as the predominant compromise formation. Similarly, though depressive moods may appear in any hysterical neurosis, some children respond to their guilt and anxiety with sufficient depression so that the sadness, expressions of unworthiness, and self-abnegation take precedence over the other symptoms.

The treatment of choice for most psychoneuroses of childhood is psychoanalytic psychotherapy. Aimed at helping the child overcome the blocks to his progressive development, the psychotherapy utilizes an object relation with a reliable and interested adult to strengthen the child's more mature defensive and adaptive ego functions and to diminish the hold of pathological modes of dealing with conflict and anxiety. Fantasy material and transference elements often appear and may be used in psychotherapy. When developmental stasis threatens several important lines of development and the child's problems though clearly neurotic are of long-standing, psychoanalysis should be considered, since it permits a systematic exploration and working through of the neurotic conflicts. A consultation with a child analyst, followed perhaps by his diagnostic exploration, can clarify issues of diagnosis, choice of management, and prognosis for the family and referring agent. Each child psychiatric facility regularly sees children for whom psychoanalysis is indicated: Where child analysts are available, their services for diagnosis and psychoanalytic treatment should be utilized as one element in the range of comprehensive child services.

Psychoeducational techniques, group activities, and/or drug therapy may be needed to supplement psychotherapy. To use these approaches as replacements for one-to-one psychotherapy does not give the child an optimal opportunity to master developmental and situational conflicts and to promote his personality growth.

The Personality Disorders

A large number of grade school children referred to child psychiatrists, clinics, and mental health centers today make up a fourth major grouping, the character and chronic behavioral disturbances or as the GAP report terms them, the personality disorders. The GAP classification lists the following subcategories: compulsive personality; hysterical personality; anxious personality; the overly dependent, oppositional, overly inhibited, overly independent personalities; the isolated and the mistrustful personalities; the tension-discharge disorders, the sociosyntonic personality disorders, sexual deviation; and other personality disorders. The descriptions of these subcategories point to the usefulness of the continuum concept in discussing this major grouping:

> At one end are relatively well organized personalities with, for example, constructively compulsive traits or somewhat over dependent characteristics representing mild to moderate exaggeration of healthy personality trends. . . . At the other end are markedly impulsive, sometimes poorly organized personalities that dramatically come into conflict with society over their sexual or social patterns of behavior.

Each classifier and many clinicians have tended to divide up this group using terms to suit their own preferences and experiences. However, whether their disturbances are called character disorders, behavioral disturbances, or personality disorders, these children tend to resemble one another in the relative rigidity and chronicity of their pathological trends. The extent of the pathological handicaps will of course vary with the location of the condition on the diagnostic continuum, and within any one subcategory, children will differ in their susceptibility to change and limitation of functioning.

In contrast to the children suffering from neurotic disorders, children with serious personality or character disorders do not experience an inner sense of conflict, always present in the former group. The battle is between them and the outside world, that is, their parents, the teacher, the police, or courts but not within themselves. They are markedly unable to tolerate delay or frustration, and their capacity to bear ambivalence, anxiety, and depression is conspicuously low; in serious cases it is almost absent. It is not surprising, therefore, that their attempts at coping are geared mainly to adapting their environment to their needs rather than adapting to it. Their relationships to people are shallow and mainly based on need fulfillment. Their orientation is self- rather than other-directed. Their superego is not patterned after an identification with a respected and loved parent figure, but appears mainly the product of early childhood projections and views of adults as cruel, ruthless, intransigent, and exceptionally powerful.

We find, on closer scrutiny of these children, serious defects in reality testing, distortions in their self-image of almost delusional fixity, and a paucity of adaptive and defensive ego mechanisms perhaps best characterized by the phrase “few strings on his bow.”

In their histories we repeatedly encounter serious disturbances in the quality of the early mother-child relationships, such as emotional neglect owing to depression and withdrawal on the part of one or both parents, unpredictability and inconsistency on the part of the child’s mother, an identification of the child by the parent with a hated, disturbed, or delinquent relative, wife, or husband. These are factors that seriously affect a child’s relationship to his early love objects and from them, people in general.

Bowlby’s first work with delinquents led him to study the early history of these boys: He found a conspicuous number of instances of separation from and loss of the mother during the first three years of life. Such an experience of maternal loss was particularly common in those children whom he called “affectionless characters,” that is, those boys with no apparent relatedness to others and a very limited capacity to make a relationship when one was available to them. The refinements of Bowlby’s formulations, which further research has elucidated, brought out (1) that the loss of the mother may have been symbolic and not actual, due to a mother’s postpartum depression, a chaotic family situation, or her serious physical illness; and (2) that the

provision, planned or fortuitous, of a mother surrogate during the early months and years of a child's life could counter the destructive effects of physical or psychological absence of the biological mother.

Some of these patients have been moved from one foster home to another, deserted at birth by their parents and adopted by no one. Some lost their parents because of the latter's severe psychopathology, which rendered the child intolerable to them when he began to assert his independence. A series of losses not infrequently punctuates the child's life, and his capacity to care about others is seriously incapacitated.

These children suffer from low self-esteem, which they try to counter by negation. They have to prove their power, vulnerability, and cunning repeatedly to themselves and to deny their rage and frustration by rationalization, denial, and projection.

The concept of the continuum of severity of personality disorders is useful to alert us to the possibility that a child's emotional disorder may change over a period of observation. Though we are more apt to be impressed by the children who move from the less to the more serious end of the emotional disturbance continuum, we need to keep in mind that precisely because our patients are children, change toward less restrictive and more hopeful states is possible and does occur. Developmental thrusts and

unexpected life situations can influence pathological trends so that significant positive change takes place even in a child with relatively fixed and widespread pathological trends. Certainly until puberty and adolescent reorganization have wrought their changes, we cannot view even severe character disorders as rarely susceptible to change. During the grade school years, the coming together of such a youngster with an adult who cares for him can effect a significant change in his object relating, his behavior, and his general ego growth. These possibilities should be kept in mind in planning therapeutic management for all the boys and girls who fall within this broad rubric of personality disorders.

For many grade school children with personality disorders on the nearer to the neurotic end of the continuum, psychotherapy may be very effective. A consistent caring object who will become a stable element in the child's life, to whom he can return when new crises, losses, or developmental demands again restrict or cut him off from rewarding relationships and activities, can help the child modulate his fixed attitudes and reach out for new objects and achievements. These children can become attached to the setting so that they expect help from "that place" even if the therapist is no longer there. A long-term investment of the facility, even though there will be many periods of silence from the child, is indicated; it is not likely that one round of treatment will be sufficient to keep him moving forward unless he is fortunate indeed in his life situation. This is particularly the case with

children displaying schizoid, paranoid, or obsessional character traits.

Time-limited psychotherapy with a focus on loss and separation offers a great deal to these children. They are more apt to be referred when their equilibrium is upset by significant losses, a father leaving, the death of an older brother, a depression of the mother. The re- experiencing of recent and more remote losses in the setting of a therapeutic relationship, which the child knows is specifically limited in time, can promote a degree of mastery of loss and a forward thrust that is surprising if one has not witnessed the changes possible. Follow up and contacts with the family after the termination of the treatment are wise.

Group therapy is a felicitous approach for most children in this large category. Because of early deprivations and ambivalences toward adults, they are prone to reach out to their peers and gain important nutriment for growth through group identifications, support, and new activities. Individual and group therapy can go on simultaneously or one follow the other. In the interests of using professional time and the family's time wisely, the decision about which modality or what sequence should be made following the diagnostic process.

Psychoeducational techniques in psychiatric day-care programs are becoming popular and may well hold promise as they stimulate the child to

learn and to achieve with his peers and in an understanding milieu.

Drug therapy for overactive, overanxious, depressed, or paranoid children is a modality that should be used alone or in combination with other treatment approaches on the basis of a diagnostic rationale. Careful medical supervision and evaluation of drug effects are important.

For certain very deprived and character- disordered children, the encouragement and support of their relationship with an adult important to them are the key to promoting their development. A scoutmaster, agency worker, probation officer, or "big brother" may with professional guidance use his tie to the child to achieve far more than a new therapist or a specific new modality could. Agency resources for camping, recreational programs in settlement houses, and medical care can make up useful facets of a total push program to which the child's response can be gratifying to all.

Children with antisocial character disorders may be more amenable to a variety of treatment modalities if these are carried out within the context of a court or youth service connection. Limits put on these children and their families are apt to be necessary if any psychiatric or mental health approach is to be helpful; the personnel of such agencies can often supply important relationships and opportunities so that more of a total push on the child's behalf is feasible.

Conclusions

We have presented the thesis that events of the past decade have propelled us to plan for and work with a much wider variety of children as well as a much larger number of children than was true in the past. We have pointed out the crucial role of nosological classifications and the diagnostic process in selecting the most likely modes of therapeutic management for a specific child at that point in time. Our conviction that we need more systematic and sophisticated clinical and epidemiological research to guide our efforts in planning for and caring for hundreds of thousands of disturbed children in this country has, we hope, been made vividly evident. We have encouraged our colleagues to use the GAP report classification, or others if they prefer these, but to press on with planning our comprehensive services for children on a more rational and scientific basis. We have discussed four major groupings of children and offered certain management suggestions.

The number of children with serious emotional disturbances in this country faces us with an urgent problem in child care. We identify daily in our clinics and offices many examples of severe emotional and intellectual dysfunctioning. But these are children; they have the forces of development on their side. They are susceptible to positive as well as negative changes in their life situations. We have much to hope for and much to do if we use our knowledge, refine our techniques, and unearth more precise ways of fitting

our management measures to the assets and needs of the children for whom we are responsible.

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