DIFFERENTIAL FACTORS IN THE DIAGNOSIS AND TREATMENT OF EMOTIONAL DISTURBANCES ROOTED IN EARLY MATERNAL DEPRIVATION

by

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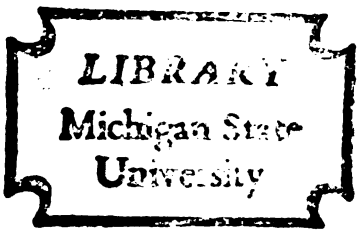

Invocation:

Eternal God,
The poet said,
"There is only one child
in the world
and his name is All Children.
Help us, O Lord, to strive together
for the wisdom and maturity
to serve
All Children;
To protect and to guide them,
To limit and to free them,
To sustain and to trust them,
To enjoy and to cherish them;
and finally,
To gratefully know that we win
when we lose them to their
maturity.

Amen.

By Winifred Weedon

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INTRODUCTION

This study was undertaken for the purpose of focusing on the impact on social functioning of maternal deprivation during the infantile and early pre-school years.

The problem was to attempt an examination of the presence or absence of early maternal care as an important variable in the diagnosis of adequate social functioning or inadequate social functioning. The purpose of the study was to identify the role that the absence or presence of early maternal care plays in the determination of social functioning. In accordance with this purpose the following hypotheses were developed: (1) a positive and significant relationship exists between maternal deprivation and the adequacy of social functioning, i.e., the greater the maternal deprivation the lower will be the adequacy of social functioning. (2) As a corrolary of hypothesis 1, it was hypothesized that individuals whose social functioning is regarded as adequate will have had a greater amount of maternal gratification during their infancy and early childhood years than those individuals whose social functioning is regarded as less adequate.

In the effort to classify the material gathered, the study developed into an attempt to provide an etiological classification of emotional disturbances and mental illnesses which appeared to arise out of early maternal deprivation.

The study is divided into four major sections or parts. Part one which includes chapters one and two is devoted to a review of available literature which is concerned with the study of the factors dealing with primary conditioning in the mother-child relationship by examining the psychological and sociological preconditioning elements which proceed out of the biological preconditioning of the maternal organism occurring during pregnancy and at the time of delivery.

Part two is devoted to the classification and description of early emotional disorders believed to be due to partial maternal deprivation. Part three is devoted to the classification and description of early emotional disorders due to total maternal deprivation. Also included are some of the methods of treatment which are currently known. The clinical pictures of these disorders are presented as follows: syndrome, etiology, and prognosis and treatment.

The major terms of total and partial deprivation have been defined as follows: (1) The term total deprivation is used to describe cases where the mother or mother substitute is physically absent from the child. Implied in this physical separation is an absence of essential emotional nurture required by the child for even his minimum security needs. (2) The term partial deprivation is used to describe those

cases where the mother or her substitute is present but where the emotional component of her presence is inconsistent, to a degree, non-existant or where the mother's ambivalence toward the child may have destructive effects on the child in varying degrees thereby limiting the potential for developing adequate social functioning.

Part four includes a discussion and analysis of the clinical pictures of early childhood disorders rooted in early maternal deprivation and points up their specific implications for social work in particular.

It is hoped that this study may lead to further research in the area of planning epidemiologic and other etiologic studies which will lead to the refinement and validation of the lists of pathogenic factors currently evident in very early childhood emotional disorders and thus to effective methods of combating these disorders and ultimately to prevention of them. Once this is achieved, it will be necessary to communicate the implications of these findings to community leaders and hence to the public. Implimentations of these studies should follow.

Part 1

PRIMARY CONDITIONING IN MOTHER-CHILD RELATIONSHIPS

Chapter 1

CONDITIONING IN THE MOTHER-CHILD RELATIONSHIP PRIOR TO DELIVERY

It is believed that the devlopment of a healthy mother-child relationship begins in utero with the mothers changing concept of herself. A survey of the literature seems to show that many of the psychological elements of pregnancy evolve out of the biological changes occurring in the mother and that it is these elements which act to prepare the total organism for her maternal role.

Experimentation with animals sheds some light on the processes that preconditions the organism for motherhood.

In an experimental study with rats, the development of maternal behavior was observed in an effort to learn how this behavior develops within human mothers. It was learned that complex relationships are established between the animal and parts of itself, and that under appropriate conditions these relationships are extended thereby permitting the animal to relate to its offspring sufficiently.

In this experiment it was observed that the normal animal did a great deal of self-licking. A substantial amount of the licking was increased during pregnancy, due to the

irritated condition of the genitalia. Disturbance in salt metabolism led to an increase in urine drinking during pregnancy. Thus possibly a tro-phalactic relationship was developing between the head end and the hind end of the rat. The lieking functions stimulated the anogenital area, while at the same time the excretory products of these regions furnished both gustatory stimulation and dietary materials to the animal. These inter-stimulations provided the objective conditions for the establishment of a social relationship between the animal and parts of itself which at parturition can be transferred to the off-spring. When the rat licks itself it must also learn to inhibit biting activity.[1]

Some other pertinant factors not discussed or considered by the experimenters is that the animal accepts the complete bodily needs which may include the additional needs precipitated by the state of pregnancy and in so doing is better able to accept the products of that pregnant state. Thus she is more capable of giving her offspring the security of the physically and emotionally nourishing part of the mother-child relationship which leads to a gradual infusion and incorporation

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[1]Herbert G. Birch, "Sources of Order in the Maternal Behavior of Animals," American Journal of Orthopsychiatry, XXVI (April, 1956), pp. 279-281.

of the mother by her child. This gradual incorporation leads to a positive identification with the mother and a gradual physical separation from her. It is believed that these same potential characteristics are also true of the human mother. However, due to the distorted social concepts that society often expresses regarding the very biological nature of the early mother-infant relationship, the human mother is often psychologically limited in her ability to fully enjoy her child as a biological being, thereby releasing the child to develop to the fullest, his potentials for absorbing and developing all the qualities of intelligence and spirituality that society desires.

It was also observed that there were chemically stimulating characteristics in the young which were essential for eliciting adequate behavior. Therefore, maternal behavior might not appear unless the offspring have gustatory characteristics equivalent to the animal's own ano-genital area.[2]

Theresa Benedek illustrates the growth of motherliness through the total feminine biological processes including not only pregnancy and motherliness but also the sublimation processes (which may be present without pregnancy). She states:

> The psychodynamic processes accompanying pregnancy can easily be understood in the light of the progestin phase of

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[2] Ibid., p. 281.

the sexual cycle. Through the monthly repetition of the physiologic processes the woman prepares bodily for pregnancy. At the same time there is a corresponding emotional state which prepares her for the introversion of psychic energies which motivates the emotional attitudes during pregnancy. The enhanced hormonal and general metabolic processes necessary to maintain normal pregnancy intensify the receptive tendencies of the woman. ------ The "surplus energy" produced by the active metabolic balance replenishes the reservoir of primary narcissistic libido which is concentrated on the self, on the pregnancy and its content, the child-to-be. Thus the psychic energy which supplies the placid, vegetative calmness and well-being of the pregnant woman becomes the source of her motherliness. Her general behavior during pregnancy may appear with-drawn and regressive in comparison with her usual level of ego integration; yet the condition which seems to indicate regression of the ego actually represents a growth of the integrative span of the personality on a biological level: motherhood encompasses the child in the psychodynemic process of the woman.[3]

She further states that the "interaction between mother and child begins immediately at conception." It is assumed that the intra-uterine growth evolves the continuous gratification of basic needs, sheltered from external disturbances. Not only are the physiological processes of the mother favorable for the growth of the fetus are transmitted, but there are recent indications that fluctuations in the mother's physical and emotional well-being may also be registered by the fetus. It is felt that such influences, together with the effects of obstetrical techniques may modify the newborn child's adaptability to extra-uterine life.[4]

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[3]Therese Benedek, "Personality Development," Dynamic Psychiatry, ed. Franz Alexander and Helen Ross (Chicago: The University of Chicago Press, 1952), IV, p. 63.

[4]Ibid., p. 63.

Dr. D. W. Winnecott has described this readiness for motherhood in the following way:

> In the earliest phase we are dealing with a very special state of the mother, a psychological condition which deserves a name, such as Primary Maternal Preoccupation. --------- of which I would say the following things:
>
> It gradually develops and becomes a state of heightened sensitivity during, and especially towards the end of, the pregnancy.
> It lasts for a few weeks after the birth of the child.
> It is not easily remembered by mothers once they have recovered from it.
> I would go further and say that the memory mothers have of this state tends to become repressed.

This organized state (that would be an illness were it not for the fact of pregnancy) could be compared with a withdrawn state, or a dissociated state, or a fugue, or even with a disturbance at a deeper level such as a schizoid episode in which some aspect of the personality takes over temporarily. I would like to find a good name for this condition and to put it forward as something to be taken into account in all references to the earliest phase of infant life. I do not believe that it is possible to understand the functioning of the mother at the very beginning of the infant's life without seeing that she must be able to reach this state of heightened sensitivity, almost an illness, and to recover from it. (I bring in the word 'illness' because a woman must be healthy in order to develop this state and to recover from it as the infant releases her. If the infant should die, the mother's state suddenly shows up as illness. The mother takes this risk.)[5]

Grete Bibring describes pregnancy as a disturbance similar to that of adolescence, arising from the facts of pregnancy themselves, be they emotional, physiological, or social. She states:

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[5]D. W. Winnecott, Collected Papers: Through Paediatrics to Psycho-analysis, (New York: Basic Books, Inc., 1958), pp. 301-302.

Stress is inherent in all areas: in the endocrinological changes, in the activation of unconscious psychological conflicts pertaining to the factors involved in pregnancy, and in the intra-psychic reorganization of becoming a mother. A new organization of all forces must be made, and this necessity leads to the crisis of pregnancy. Within this crisis, of course, individual problems and neurotic conflicts of significance are high-lighted.[6]

Miss Bibring calls attention to the fact that in the past the woman who was involved in the crisis of pregnancy was given support through carefully worked out traditional customs. However, at the present time this period has become a crisis with no mechanisms within society for helping the woman involved in this profound change of conflict solutions and edjustive tasks.[7] It was believed "that all women show what looks like remarkable, far-reaching psychological changes while they are pregnant. The outcome of this crisis then has profound effects on the early mother-child relationship."[8]

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[6]Grete I. Bibring, "Some Considerations of the Psychological Processes in Pregnancy," The Psychoanalytic Study of the Child, (New York: International Universities Press, Inc., 1959), XIV, pp. 116-117.

[7]Ibid., p. 118.

[8]Ibid., p. 119.

Chapter 2

CONDITIONING IN THE MOTHER-CHILD RELATIONSHIP FOLLOWING DELIVERY

Theresa Benedek describes the trauma of birth as the interruption of the symbiosis of pregnancy which leaves the mother with varying degrees of physiological and emotional readiness for her complex and emotionally charged functions of motherhood. After parturition, preparation for lactation the next function of motherhood takes place. The hormonal control, to lactation stimulates milk secretion and suppresses gonadal production, thereby inducing an emotional attitude similar to the progestin phase of the sexual cycle. The trend toward motherliness is then expressed actively or passively by receptive tendencies. During lactation, both the active or giving and the passive receptive tendencies gain in intensity and become the axis around which the activities of motherliness center. She states:

> The mother's desire to nurse the baby, to be in close bodily contact with it, represents the continuation of the symbiosis, not only for the infant, but for the mother as well. While the infant incorporates the breast, the mother feels united with her baby. The identification with the baby permits the mother to enjoy her "regression" and to repeat and satisfy her own receptive, dependent needs. The emotional experience of lacation and of sundry activities of nursing care, through the

> processes of mutual identification, lead step by step to the integration of motherliness.[1]

Dr. Bowlby states:

> The child needs to feel he is an object of pleasure and pride to his mother; the mother needs to feel an expansion of her own personality in the personality of her child; each needs to feel closely identified with the other. The mothering of a child ----- is a live human relationship which alters the characters of both partners.[2]

Continuity is not only necessary for the baby but also for the mother. Just as the baby needs to feel that he belongs to his mother, the mother needs to feel that she belongs to her child. It is only when she has the satisfaction of this feeling that it is easy for her to devote herself to him.

Nathan Ackerman states that under normal conditions the welfare of the infant and mother are one and that the mother need make no sacrifice for the infant. The mother's physical and mental health is enhanced through her care of the child. Breast feeding promotes rapid contraction of the uterus after birth and favors a rapid glandular balance in the mother. Through a good psychological union between mother and infant,

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[1]Therese Benedek, "Personality Development," Dynamic Psychiatry, ed. Franz Alexander and Helen Ross (Chicago: The University of Chicago Press, 1952, IV, pp. 103-104.

[2]John Bowlby, "The Purpose of the Family," Child Care and the Growth of Love, (Harmond sworth, Middlesex: Penguin Books Ltd., 1959), p. 75.

she fosters homeostasis and effective development of autonomy in both of them and thus promotes health in both the infant and herself.[3]

Dr. Winnecott discusses the influences of outside forces that may have a bearing on the mother's ability to give the kind of mothering the child needs and she may wish to give. He states that if it is true that the mental health of every individual is founded by the mother in her living experience with her infant that doctors and nurses should not interfere but recognize a good mother and to provide her the full opportunity to "grow to her job."

> "Mothers cannot grow if they are frightened into doing as they are told. They must first find their feelings, and while doing so they need support--support against their own fears, their superstitions, their neighbors."[4]

Dr. Winnecott discusses the need of the infant for a "shared reality" which is an aspect of objectivity that is not established, and in the beginning everything depends upon the mother, a job which she accomplishes by being devoted and permitted generally to act as she loves to do. She needs to

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[3]Nathan W. Ackerman, "Homeostasis of Behavior," The Psychodynamics of Family Life, (New York: Basic Books, Inc., 1958), V, p. 76.

[4]D. W. Winnecott, "Paediatrics and Psychiatry," Collected Papers: Through Paediatrics to Psychoanalysis, (New York: Basic Books, Inc., 1958), pp. 161-162.

be allowed to come to terms with her infant after birth in her own way, which is the infant's way.[5]

He further states that a feeding difficulty could often be cured by advising mothers to "fit in with the baby absolutely for a few days." It was discovered that this fitting in with the infant's needs was so pleasurable to the mother that she could not do it without emotional support, or else she would "wilt" under criticism and feel responsible for too much. In obeying a rule, she could blame others if things went wrong, but she was scared to do as she so deeply wanted to do. If all goes well, she never forgets the fact that she had it in her to do the right thing for her baby, without help.[6]

Dr. Bowlby has described the dynamics of the libidinal tie which develops between the mother and child during the first year of life by discussing four theories concerning this tie, that of the secondary drive theory in which the child becomes attached to the mother because she meets his physiological needs; that of the primary object sucking theory which concerns the innate drive to relate to the breast and learns that the mother is attached to the breast; the primary object clinging theory in which the infant has the innate need to

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[5]Ibid., pp. 163-164.

[6]Ibid., p. 165.

cling to and be in touch with a human being and the primary need to return to the womb craving theory. He advances an hypothesis incorporating two of these theories, that of primary object sucking and primary object clinging. He feels that the behavior of a year-old child is made up of a number of instinctual responses, which in the beginning are relatively independent of each other, and which mature at different times and develop at different rates, which includes sucking, clinging and following.[7]

Dr. Bowlby believes that theoretically infants are instinctively made to cling, follow, smile and babble at their mothers and that these instincts have survival value in the same way that crying and sucking do.[8]

It was also thought that these instinctual responses were instrumental in insuring that the infant in attaching himself to his mother evokes in her a powerful reciprocal impulse to attach herself to him and to care for him.[9]

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[7]John Bowlby, "The Nature of the Child's Ties to His Mother," Digest of Neurology and Psychiatry, series 27, (1959), p. 55.

[8]John Bowlby, "A Psycho-analyst Learns From Animals," Child-Family Digest, Vol. 18, No. 3, (May-June, 1959), p. 3.

[9]Ibid., p. 6.

Dr. Bowlby utilizes a study by Anthony Barnett which describes how young rats which are brought up in different ways varied in their "emotionality." Those which were stroked were less anxious and grew better, and in some experiments survived better, than those who were left isolated. It was felt this might also apply to human infants.[10] Dr. Bowlby indicates that it is fairly clear that the need of the small child to attach himself to one particular person is important and favorable since within these primitive ties and loyalties are to be found the roots of morality.

Anna Freud says:

> "The child's obligation to cleanliness and inner prompting exists but is only worthwhile to the child while the person responsible for its establishment retains her place as the loved object in the outer world. Where the object relationship lapses, so does the satisfaction in fulfilling the obligation. ----------Any dislocation of child's ties with its parents may disturb its moral development and formation of character."[11]

According to René Spitz, the progressive development of emotional interchange with the mother provides the child with the perceptive experiences of its environment. The child learns to grasp by nursing at the mother's breast and

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[10] Ibid., p. 7.

[11] Anna Freud, "The Analysis of Children and Their Upbringing," The Psychoanalytic Treatment of Children, (Imago Publishing Company, 1946), Part I, Lecture 4, p. 42.

combining its emotional satisfactions with tactile perceptions. He learns to distinguish between animate and inanimate objects from the emotional satisfactions provided by the sight of his mother's face. It is within this emotional environment that he learns to play and becomes acquainted with his surroundings through the mother's carrying him around. Through her help he learns security in locomotion which is reinforced by her being at his beck and call. In this way, he is introduced to learning and imitation.

> "It is the security provided by the mother in the field of locomotion, the emotional bait offered by the mother calling her child, that "teaches him to walk." When this is lacking, even a child of two or three years will be unable to walk."

It was thought that the presence of the mother was sufficient to compensate for all other material deprivations.[12]

Ackerman says that the potential homeostasis of the child is a function of the symbiotic union of mother and child. In the beginning the infant's capacity for homeostasis is limited and his survival hinges on the mother's homeostatic capacity. Deficiency or distortion of the mother's homeostatic powers will instantly be revealed in disturbances of complementarity and interchange between mother and child and will

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[12]Rene Spitz, "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," The Psychoanalytic Study of the Child, (New York: International Universities Press, Inc., 1945), I, pp. 66-67.

result in an impairment of the infant's homeostatic development.[13]

> "Whether the inappropriate mothering emerges as neglect, overstimulation, or direct, hostile assault, the infant will tend toward a more rigid, constricted, static equilibrium and the homeostatic capacity of the infant will in consequence be injured. Neglect of the infant's needs evokes an excess of stimuli from within the organism. A superabundance of handling of the infant or direct, hostile assault stirs turmoil and tension. The excess of stimulation, whether from without or from within, overwhelms the infant, exceeds his shock barrier, and overrides his capacity to slow the pace of change, in keeping with his limited resources for adaptation.[14]

The general direction of development is from a bio-social union with the mother to a separate existence, from dependence on mother to self-dependence. The maturing infant moves towards autonomy and a healthy, genuine autonomy emerges only as a satisfying and healthy union is maintained.[15]

Neurotic mothers who exploit the theme of "sacrifice" do not in actuality exact a sacrifice but exploit their children by their imagined wounds and constant reminders of all they have done for them. Neurotic children take this seriously

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[13] Nathan W. Ackerman, "The Homeostasis of Behavior," The Psychodynamics of Family Life: Diagnosis and Treatment of Family Relationships, (New York: Basic Books, Inc., 1960), V, p. 75.

[14] Ibid.

[15] Ibid

and attempt in a futile way to make up to their mothers for the presumed sacrifice. "Such patterns of neurotic interaction bind the child to the mother, deform the quality of togetherness, and sharply restrict the range of development toward a mature autonomy."[16]

How do some of the abnormal conditions lead to the creation of negative or abnormal attitudes in the mother towards her child?

To refer back to the previously mentioned experiment conducted with rats: It was found that when the rats were prevented during pregnancy from the preconditioning acts of self licking by placing heavy collars around their necks, the maternal behavior of the animals became markedly abnormal upon parturition. The maternal behavior was so inadequate that no offspring were able to survive the nursing period. The latent periods for the initial licking of the offspring were abnormally long and once begun, the mothers literally consumed their pups. Only 5 per cent of them survived the postparturitive period and these were not readily retrieved. Those that were rescued were found to be badly suckled. Some were eaten by the mother after being carried to the nest. In one instance of a very large litter, three pups surviving

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[16] Ibid.

parturition were found to be starved to death by the mothers behavior. Although fluid could be expressed from the mothers nipples, upon post-mortem examination, all of the pups were found to be empty. In the nest she kept her pups under her chin. When they attempted to reach the belly region she used her paws to push them forward under her chin, and thus they could never secure nourishment. An apparently abnormal intra-animal relationship had developed which was transferred to the pups. It was thought that this indicated that the "where" of behavior as well as the "if" and "how" of maternal behavior may be determined by patterns of behavior laid down through the prepartuition experience. It was found that isolating the rat during pregnancy had no noticeable effect upon maternal behavior.[17]

It was felt that this study suggested that "novel and complex adaptive patterns which apparently spring forth "whole" and full blown may be the product of the knitting together by experience and immediate situational factors of a loose and relatively independent series of hormonal, dietary, stimulational, and experiential phenomena." It was concluded that the maternal behavior of the rat suggested that in mammalian

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[17]Herbert Birch, "Sources of Order in the Maternal Behavior of Animals," American Journal of Orthopsychiatry, XXVI (April, 1956), p. 283.

organisms the relation of the mother to her offspring might well be an extension of her acquired relations to herself.[18]

Sylvia Brody in a study of disturbed mother-child relationships during early infancy found that in cases where sharp likenesses of maternal and infant behavior were absent, there were sharp dissimilarities. Mothers who were dominating had infants who were often noticeably passive or noticeably active; Mothers who were generally elated had infants whose social maturity was advanced, sometimes to the point of too easy excitement; mothers who were steadily kind and affectionate had infants who responded with appropriate affect but sometimes lacked drive; mothers who spoke a great deal had infants whose vocalizations were superior in quantity and quality.[19]

One should look for such characteristics as apathy, withdrawal, exclusive preoccupation with a few activities, hyperactivity or hypersensitivities within the behavior of the mother. The more they are in evidence, the more we should be warned that the maternal influence may be at work in such a way as to interfere with the instinctual balance of the infant. It is during the first year that the infant is generally more

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[18] Ibid.

[19] Sylvia Brody, "Signs of Disturbance in the First Year of Life," American Journal of Orthopsychiatry, Vol XXVIII (April, 1958), p. 366.

vulnerable to the impacts of internal and external stimuli than he will be at any further point in his ego development and therefore every continuous experience at the hands of the mother during this period counts heavily in the formulation of his personality.[20]

Theresa Benedek states:

> "Motherhood, through the libidinally charged process of pregnancy and motherliness, sets in motion a reorganization in the mother's personality. To be a good mother and love the child--to be able to respond to the child's needs in the most constructive manner--is the ego ideal of every normal mother; if she fails, she feels punished by the child as much as, or even more than she ever felt punished by her parents. Thus the child, through his unceasing needs, becomes a strict superego of the conscientious mother. As the child becomes older, the mother's identification with him becomes more complex. While the mother consciously strives to make the child's needs and goals a part of her own ego aspirations, unconsciously she may project onto him her own expectations, hopes, and frustrations. One mother may burden the child with the hope that he will satisfy her aspirations; another may reject the child because of her own frustrations, assuming that her child being like herself, cannot or will not be able to undo her own failures. Thus the mother, reliving with her child, and with each child in an individually significant way, those emotional experiences which determined her own development, is a conveyor of the past and a participant in the future at that same time."[12]

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[20] Ibid., 367.

[21] Benedek, loc. cit., p. 107.

Part 2

THE EFFECTS OF PARTIAL DEPRIVATION

Chapter 3

SYMBIOTIC INFANTILE PSYCHOSIS

Symbiosis is a condition in which a person depends upon others, not for cooperative mutual support and affection but for exploitation and the satisfaction of neurotic needs.[1]

SYNDROME

Mahler believed that "bi-sexual conflict can be, and often is prominant in the symptomatology, the production, and even the immediate cause of the psychotic breakdown of the ego in childhood.[2] Dr. Greenacre conveyed the following statement in a private communication with Dr. Mahler: "in children suffering from severe and early traumata there is a condition of increased plasitcity of the body responsiveness which may under certain conditions produce a severe bi-sexual identification. There are then bodily hallucinations of a bi-sexual nature which persist and play an important part in the child's fantasy during the early latency period."[3]

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[1]Horace B. English and Ava C. English, A Comprehensive Dictionary of Psychological and Psychoanalytical Terms (New York: Longmans, Green and Co., 1959), p. 538.

[2]Margaret Schoenberger Mahler, "On Child Psychosis and Schizophrenia: Autistic and Symbiotic Psychosis," The Psychoanalytic Study of the Child, VII (New York: International Universities Press, Inc., 1952), p. 294.

[3]Ibid.

The characteristic mechanisms in the Symbiotic Infantile Psychosis are the introjection-projective mechanisms and their psychotic elaboration.[4] These mechanisms "aim at a restoration of the symbiotic parasitic delusion of oneness with the mother."[5] There seems to be an abnormally low tolerance for frustration and later a lack of emotional separation or differentiation from the mother. The clinical symptoms manifest themselves between 2 and 5 years of age with a peak of onset in the fourth year.[6]

Agitated catatonic-like temper tantrums and panic-stricken behavior seems to dominate the picture. This is followed by bizarrely distorted reality testing and hallucinatory attempts at restitution, the aim of which is restoration and perpetuation of the delusional omnipotent phase of the mother-infant fusion of early infancy.[7] The manifestations of love and aggression in the child's impulse-ridden behavior appears completely confused. The child craves bodily contact and seems to want to melt into the body of the adult and yet will often shriek at any body contacts or over demonstrations of affection

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[4] Ibid., p. 297.

[5] Ibid.

[6] Ibid., pp. 297-298.

[7] Ibid.

by the adult. Their biting, kicking and squeezing the adult is the expression of their craving to incorporate, unite with, possess, devour and retain the "beloved." There is confusion between the self and the mother as well as a lack of direction between libidinal and aggressive tendencies.[8]

Reality testing remains fixated at, or regresses to, the omnipotent delusional stage of the early mother-infant relationship.[9]

The symbiotic child seldom shows conspicuously disturbed behavior during the first year of life, except possibly disturbances of sleep. Their mothers may describe them as having been "crybabies" or oversensitive infants. The disturbance may become apparent gradually or fulminantly at the crossroads of personality development at which maturational function of the ego usually effects separation from the mother and thus enables the child to master an ever-increasing segment of reality, independently of the mother. When the ego begins to differentiate and psychosexual development confronts the child and challenges him with a measure of separation from and independence of the mother, the symbiotic omnipotence illusion is threatened and severe panic

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[8]Ibid., p. 299.

[9]Ibid., p. 293.

reactions occur. These reactions usually become apparent in the third or fourth year or at the height of the oedipal conflict.[10]

The boundaries of self and non-self are blurred and the mental representation of the body-self is unclearly demarcated. When in contact with understanding adults it seems as though their body contours melt into that of the adult.[11]

There is often a peculiar hypercathexis of one part of the body encountered in the symbiotic psychotic child in which the parental psychopathology appears quite evident. The adult partner often seems able to accept the child as long as the child belongs as a quasi-vegatative being, as sort of an appendage to her or his body. There may be marked coincidences between the childs overconcern about certain parts of his body or certain bodily sensations to that which the parent or adult partner in the symboitic relationship also seems overly concerned within his own body.[12]

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[10] Ibid., p. 292.

[11] Ibid.

[12] Ibid., pp. 293-294.

There seems to be an original lack of self-differentiation which is considered the crux of the symboitic relationship.[13]

Prolonged listening to music and compulsiveness may be considered as autistic like defenses against separation from the mother which might be developed or evident at the time of another pregnancy in which the child may experience the parents' relative detachment as though part of the self which is necessary for survival is slipping away from the childs control.[14]

Contact with playmates may meet with complete lack of interest, or more often with abject terror. The child may become subjected to unprovoked beatings by neighborhood children, and until such beatings reach a certain intensity, the child may stand motionless, laughing inappropriately, than run to the mother, sobbing quietly.[15] There is an overwhelming terror over threatened separation from the parent figure.[16] There is failure of repression of early events or the process of syncretically related affect and events may

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[13]Tarlton Morrow, Jr. and Earl A. Loomis, Jr., "Symbiotic Aspects or a Seven-Year-old Psychotic," Emotional Problems or Early Childhood, ed. Gerald Caplan (London: Tavistock Publications Limited, 1955), XVI, XVI, p. 345.

[14]Ibid.

[15]Ibid., pp. 346-347.

[16]Ibid., p. 346.

be illustrated in subsequent similar incidents in which the child may become disproportionately upset.[17]

ETIOLOGY

Mahler believed that the main cause of proclivity for alteration of the ego from reality and fragmentation was due to a grave disturbance and specific conflicts in the mother-child relationship.[18]

Despert has pointed out the significance of emotional frigidity in the personal history of mothers in which there is a consequent disgust and rejection of close contact with the infant, such as touching, cleaning, rubbing, holding, and fondling the product of sexual activity.[19]

There seems to be indications that the childs demands are not appropriately met due to the parents excessive anticipation of the childs needs, thereby denying the child the right to demand. As the result of anxious oversolicitousness, the child's normal cycle of frustration-gratification-rest is seriously disturbed. This attitude thereby undermined the child's potential ability to control his own inner tensions

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[17] Ibid., p. 352.

[18] Mahler, loc. cit., p. 294.

[19] Morrow and Loomis, loc. cit., p. 340.

and leads to the early enhancement of a very pathological dependency upon the mothering figure of figures, thus laying the foundation for pathological symbiosis and making it virtually impossible for the child to subsequently separate from the external agent of his own ego activity.[20]

The "landmarks of fragmentation of the ego are traumatizations through sickness, separation (for instance placement in a nursery school), and birth of a sibling."[21] All kinds of minor changes also contribute to upsetting the precarious psychobiological balance.[22]

There seems to be a preoccupation with a certain part of the body which often corresponds to the type of overstimulation occurring during symbiotic relationships.[23]

Factors such as early and prolonged illness or pain interferes with the fusion and blending of good and bad images of objects and self. In constitutionally oversensitive and vulnerable infants the pathogenic effects of intrapsychic events may become enhanced, thus setting the prepsychotic stage if fixation to the symbiotic phase is reinforced during

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[20]Ibid., p. 341.

[21]Mahler, loc. cit., p. 292.

[22]Ibid.

[23]Ibid., p. 294.

the phase of individuation.[24] The auxiliary events may occur in the cases where mothers are over-stimulating, over-protective, and anxious or emotionally unavailable symbiotic partners.[25]

The mother may continue her overprotection beyond the stage where it is beneficial. Thus there develops an enfulfing threat, detrimental to the child's normal disengagement and individuation from his second year on. Another kind of symbiotic parasitic mother is the one who cannot endure the loss of her previous vegetative appendage, but has to do so, at least on an emotional basis, and therefore sloughs the child off abruptly.[26]

Bowlby has stated that in the actual separation of the small child and his mother, both the good and bad images of the mother undergo rapid changes. The good mother becomes glorified and the bad mother a hateful image.[27] Even a normal two-year old will temporarily have difficulty identifying his

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[24]Margaret S. Mahler and Bertram J. Gosliner, "On Symbiotic Child Psychosis: Genetic, Dynamic and Restitutive Aspects," The Psychoanalytic Study of the Child, X (New York: International Universities Press, Inc., 1955), p. 201.

[25]Ibid.

[26]Ibid., p. 203.

[27]Ibid., p. 207.

his inner images with that of the real mother after a period of separation.[28]

Mahler and Gosliner advance the following concept regarding the importance of the father:

> "the stable image of a father or of another substitute of the mother, beyond the eighteen-months mark and even earlier, is beneficial and perhaps a necessary prerequisite to neutralize and to counteract the age-characteristic over-sensibility of the toddler to the threat of reengulfment by the mother."[29]

In further elaboration of the above they quote Loewald as follows:

> "against the threat of the maternal engulfment the paternal position is not another threat of danger, but a support of powerful force."[30]

They further state that:

> "If there is a relative lack of support on the part of either parent (or the "uncontaminated" mother substitute), a reengulfment of the ego into the whirlpool of the primary undifferentiated symbiotic stage becomes a true threat."[31]

The child in the second eighteen months, whose ego is constitutionally vulnerable, symbiotically fixated and then during the separation individuation phase is additionally

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[28] Ibid., p. 208.

[29] Ibid., p. 209.

[30] Ibid., p. 210.

[31] Ibid.

traumatized, may regress to earlier infantile phases of personality development. This lapse into the early infantile objectless, autistic phase may be the only solution. The child may suddenly or gradually lose his individual identity and contact with reality.[32] It is thought that the pyschotic autistic form of negativism is an attempt at restitution.[33]

PROGNOSIS AND TREATMENT

It is thought that the prognosis as to arrest of the process and to the consolidation of the ego is moderately favorable and depends on the right type and the cautious, prolonged and consistent nature of therapy. Therapy should be of a kind of substitution of infusion therapy. The outlook as to a real cure is presently not too promising.[34]

It is important to permit the symbiotic child to test reality very gradually at his pace. As he begins testing himself as a separate entity he has a constant need to feel the support of an understanding adult. These continual infusions of borrowed ego strength may have to be continued

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[32] Ibid.

[33] Ibid., p. 211.

[34] Mahler, loc. cit., p. 303.

[24] Mahler, [illegible] op. cit., p. 303.

[25] Ibid., p. 311.

[26] Ibid.

for a lifetime. Separation as an individual entity can only very cautiously be continued with the symbiotic psychotic child.[35]

Any pressure in sudden separate functioning must be causiously avoided, for if the ego of the symbiotic child is overestimated and expected to be able to cope with reality without continual ego infusion from the therapist, the panic reactions and acute hallucinations could cause regression and withdrawal into a stuporously autistic state or hebephrenic reaction.[36]

It is hoped that the patient will utilize the therapist as an extension of himself and as the means toward achieving various primitive gratifications.[37] As the hostile aspects of the symbiosis become dominant, the patient will identify with the fantasied aggressor and in various ways play act murder of the therapist and self-destruction. He may also escape into autism via hiding, primitive self-preoccupations and periodic loss of contact.[38]

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[35]Ibid., p. 302.

[36]Ibid., p. 305.

[37]Rudolph Ekstein, Judith Wallerstein, and Arthur Mandelbaum, "Counter-transference in the Residential Treatment of Children: Treatment Failure in a Child With a Symbiotic Psychosis," The Psychoanalytic Study of the Child, XLV, (New York: International Universities Press, Inc., 1959), p. 201.

[38]Ibid.

The first goal of therapy is to assist the child to develop a positive symbiotic transference by diminishing his fear of annihilation by the symbiotic mother equal therpist. This might be achieved by accepting the role of the all-powerful extension of the child, by repeated assurances of protection, imitation of the child in offering of self as a partner in his endeavors, and by interpreting his fears of being destroyed.[39]

There is a need to set limits on behavior as it swings from anti-social to very regressed behavior, and to which extent such limits are necessary from a therapeutic standpoint.[40]

The structure of therapeutic care should be designed to provide the child with safety against his destructive attacks against himself, other children, adults and property. There is also the need to meet the most regressed infantile needs such as personally feeding and clothing the child. Because of the childs difficulty in maintaining a constant image and memory of those providing for him, it is wise for personnel

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[39] Ibid.

[40] Ibid.

to maintain the same shifts so as to provide constancy and stability.[41]

Alpert describes treatment methods with maternally deproved infants planned upon therapeutic relationship which would be based upon need satisfaction and gratification. This was to test the child's capacity for growth in object relations beyond need satisfaction and the extent to which the pathology could be reversed. The principal criteria used for the reversibility of the pathology was the child's capacity for growth in object relationships beyond need satisfactions, and in reality testing.[42]

Alpert cites an example of a treatment experience with a symbiotic child in a nursery. When the child was able to form a secondary symbiotic relationship with his teacher, he was able to detach himself from his mother. Thus, within this framework, the child led the special teacher on his regressive path down the zonal scale, and progressively back to a normal behavior for his age, seemingly on the strength of energies released with each regressive experience.[43]

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[41]Ibid., pp. 205-206.

[42]Augusta Alpert, "Reversibility of Pathological Fixations Associated with Maternal Deprivation in Infancy," The Psychoanalytic Study of the Child, XIV (New York: International Universities Press, Inc., 1959), pp. 170-171.

[43]Ibid., p. 171

Alpert suggests the following standardized therapeutic procedure for reversal of pathological fixations related to maternal deprivation in infancy:

"1. The first step is always to set up an exclusive, need satisfying relationship between the special teacher and the child. Such a relationship induces regression of varying depth.

2. Continued need satisfaction by the special teacher may induce further regression to the point of traumatic fixation. This regressive "unwinding of the developmental reel" exposes early developmental distortions and etiological connections and helps to localize pathology. ------ the symptomatology associated with the trauma of maternal deprivation is related to variables such as: the maturational-developmental phase when the trauma occured; probably the specific character of the maternal deprivation; the quality of mothering before separation, rejection, and/or neglect.

3. The special teacher follows and encourages the childs regressive cues by gratifying needs, as shown, repeatedly, if necessary; oral, anal, and urethral, motor, perceptual, and affective, with verbal accompaniment. This serves to reinforce the gratification, to relate it to earlier intolerable deprivation and/or frustration, and to give it more specific meaning and cathexis.

4. The special teacher uses the childs verbalization and play as cues for reconstructing, reality testing, structuring, and integration of reality. The regressive, need satisfying phase promotes a corrective relationship with the special teacher and the neutralization of drive energies, which are mobilized for a higher level of integration and functioning.

5. Just as the special teacher follows the child's regressive cues, so she also follows at a later stage the child's progressive growth cues, and supports the ego in all such strivings, within the limits of the child's ego strength. The special teacher also

clarifies incompatible strivings, thus aiding in the synthetic function of the ego.

6. The special teacher recognizes the terminal point in C O R (Corrective Object Relationships) by the childs cues; tapering-off demands for immediate and direct gratification, more ability to tolerate frustration and delay, increased participation in the regular nursery. The children seem to know ------ when they have reached psychic satiety. We have had no experience with "runaway" regression, nor with "infactious" regression, even when C O R had to be tried in the regular nursery.

7. C O R usually leasts from seven to nine months, the children having been seen by the special teacher for an hour each day, four to five times a week, in a special room set aside for this purpose."[44]

Corrective Object Relations was first set up to test the extent of reversibility of pathological effects associated with maternal deprivation. Many variables are involved in the response to C O R, such as age, psycho-sexual phase, in addition to timing, quality, and surrounding circumstances of maternal deprivation and the severity of the pathology.[45]

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[44]Ibid., pp. 181-182.

[45]Ibid., pp. 182-183.

Chapter 4

EARLY INFANTILE AUTISM

Early infantile autism was first described and reported upon by Kanner in 1943. This clinical concept refers to certain kinds of withdrawal tendencies noted as early as the first year of life. Infants have an inability to relate themselves to people and situations in the usual way from the beginning of life.[1] Parents referred to them as always having been "self-sufficient," "like in a shell," "happiest when left alone," "acting as if people weren't there," "giving the impression of silent wisdom." Case histories show extreme autistic aloneness from the start which, whenever possible, shuts out anything that comes to the child from outside. Mothers recalled astonishment at their children's failure to assume usual anticipatory posture preparatory to being picked up, a kind of adjustment normally occuring at four months of age.[2]

These children are often confused with feebleminded children and at an early age may appear to be so due to their

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[1]Leo Kanner, "Schizophrenia," Child Psychiatry, (Springfield: Charles C. Thomas, 1948), pp. 716-717.

[2]Ibid., p. 717.

extreme withdrawal and inability to respond appropriately to psychological testing. At later ages many show improved psychometric ratings and prove to be of average or superior intellectual capacity.[3]

SYNDROME

The symptoms of early infantile autism occur unmistakably in the first two years of life and consists of language distortion, social withdrawal, activity lacking integration, obsessiveness and nervousness.[4] It has been suggested that "the primary symptom of early infantile autism is a lack of integration pervading all behavior of the organism and manefesting itself in the distorted language, in the lack of social responsiveness and in the lack of adaptibility to environmental changes."[5]

Language distortion may consist of the following symptoms:

"1. Mutism past the age of usual speech development.
2. Echolalia. Speech is parrot-like and lacking in normal inflections.

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[3]C. G. Polan and Betty L. Spencer, "A Check List of Symptoms of Autism of Early Life, "The West Virginia Medical Journal, Vol. 55 (June 1959) p. 198.

[4]Ibid., 198.

[5]Ibid., p. 201.

3. Early speech is like a motor activity. Words and phrases used are unrelated to what the child is doing.
4. Is slow to learn the word "yes." Affirms and agrees by repeating the question he has been asked.
5. Does not answer direct questions or answers inappropriately.
6. Calls self by name and is slow to use pronouns, even as if they were nouns.
7. May develop a large vocabulary without communicating meaning. The rote memory is often excellent. Uses language for a long time before it is used for communication.
8. Is unresponsive to what is being said to him or in his presence. Does not seem to comprehend language."[6]

Social withdrawal may consist of the following symptoms:

"1. Detached, self-preoccupied. Disinterested, unreachable.
2. Unresponsive to affection. Is slow to distinguish between family and strangers. Cannot empathize with others.
3. More interested in objects than in people. Likes to play alone and is annoyed if anyone attempts to play with him.
4. Contact with others is painful. Face is tense in presence of others.
5. Conformity is an effort. Lacks a sense of what is appropriate. Is tactless and direct."[7]

The following are symptoms of unintegrated activities:

"1. As an infant he shows no anticipatory posture for being picked up. Is oblivious to surroundings.
2. Activities lack a purpose. Behavior is not integrated.
3. Does not organize perceptions meaningfully. Will react to a pin rather than to the person who pricks him.

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[6]Ibid., p. 202.

[7]Ibid.

4. Preoccupied with isolated sensory impressions from the environment. Cannot ignore extraneous stimuli.
5. May solve difficult abstract problems, but cannot grasp use of objects.
6. Shows ability to classify objects by putting similar objects together. For example, puts all dolls together, stuffing large dolls into small doll house."[8]

The symptoms of obsessiveness and nervousness consist of the following:

"1. Disturbed by slight changes in environmental arrangements, insists upon preservation of the sameness.
2. Rhythmical movements of the body.
3. Mechanical repetition of aimless activity. Repeats play patterns.
4. Obsessive-compulsive characteristic. Ritualism in the daily activities.
5. Often has facial grimaces and twitchings.
6. Easily frustrated. Angered by interferences."[9]

ETIOLOGY

The condition of early infantile autism is unassociated with any injury, illness or congenital abnormality. Physical development proceeds normally and the children are generally attractive. There seems to be no allergic manefestations.[10]

There is no history of psychoses in the parents or other close relatives. Almost all of the adult relatives in Kanner's

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[8] Ibid.

[9] Ibid.

[10] Harry Bakwin and Ruth Morris Bakwin, "Schizophrenie in Children," Clinical Management of Behavior Disorders in Children, (Philadelphia: W. B. Saunders Company, 1954). p. 451.

series were successful in their careers and were with few exceptions, professional people and business executives. Most of the mothers had attended college and had been active in various professions before marriage and some after marriage. Kanner has not seen a single case of infantile autism of unsophisticated parents.[11]

The parents of autistic children were possessed of a high level of intelligence, were serious minded, conscientious, disdainful of frivolity, and preferred intellectual pursuits to casual conversation. They were often perfectionists being obsessively accurate and compulsive.[12] There seem to be very few warmhearted fathers and mothers and for the most part were limited in a genuine interest in people. Some of the happiest marriages were rather cold and formal affairs.[13] The siblings are normal, except in the case of identical twins. The ratio of girls to boys is 1 to 4.[14]

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[11] Ibid.

[12] Ibid.

[13] Kanner, Loc. Cit., p. 720.

[14] Polan and Spencer, Loc. Cit., p. 202.

PROGNOSIS AND TREATMENT

Follow-up studies have shown that approximately one-third of autistic infants will achieve a fair or good social adjustment by the time of adolescense or adulthood. The presence of useful communicative speech by the age of 5 years was a good prognostic sign for later development and approximately one-half of the speaking children will achieve a good adjustment. Very few of the non-speaking children ever make an adequate social adjustment.[15]

Studies seem to indicate that treatment has little effect upon the progress of patients. None of the varieties of psychiatric treatment employed had any noticable effect. The outcome appears to be dependent on the severity of the autistic process.[16]

A special technique of psychotherapy with an autistic child is described by Dr. Nic Waal of Norway.[17]

She describes an approach consisting of anxiety-reducing and ego-building, mothering and acceptance on a non-verbal

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[15] Ibid., p. 198.

[16] Ibid.

[17] Nic. Waal, "A Special Technique of Psychotherapy With an Autistic Child," Emotional Problems of Early Children, ed. Gerald Caplan (London: Tavistock Publications Limited, 1955), pp. 431-449.

level, "just as a baby is fondled." The effect and impulses are released by a bodily massage and movement of certain parts not soothingly but provokingly.[18]

The first step is a general reduction of anxiety. This consists of a bodily approach in which the therapist gives the patient a general soft and maternal massage, with the stimuli of rhythmical petting and very gentle tickling and touching.[19]

In the second stage the pressure of the therapists hands is heavy and provocative. The patient reacts by expressing protest affects and impulses such as screaming, weeping, anger, biting, and kicking. Later, usually after aggressive expressions, the child reaches out, licks, sucks, pets, smiles, and hugs. All of these reactions are accepted, and the reduction of withdrawal and guilt feelings is verbalized. The therapist repeated that these reactions were the reactions of a disappointed baby. and that they were alright. After outbursts, there were periods of soothing and mothering for varying periods of time according to the needs of the patient. Truthfulness and warmth coupled with detachment on the part

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[18]Ibid., p. 443.

[19]Ibid., p. 443.

of the therapist was considered necessary. Uninvolved objectivity and acceptance was considered indispensable, and therapy is impossible if the therapist has any affects of aggression, shame, guilt, or frustration, or identifies in the wrong way with the patients disturbances.[20]

It was thought that the effect of this special therapeutic technique seems to be a bodily maturation and a break in autistic withdrawal. However, if the family constellation and relationship is not altered, and casework or therapy with the parents does not succeed, it is questionable that the child can be totally cured without treatment in a residential setting.[21]

A recent article in a nationally known magazine discusses the problems and anxieties faced by parents of an autistic child who were advised the child was seriously disturbed and that no treatment methods were available. They discuss having heard a lecture by Dr. Newell C. Kephart, a professor of psychology at Purdue University who discussed treating deviant children. Dr. Kephart recommended the parents take the child to his summer camp in Colorado where children with learning

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[20] Ibid., p. 444.

[21] Ibid.

problems were thoroughly studied and evaluated in terms or their learning disorders for a period of four weeks. Their parents are simultaneously taught how to work with the child during the rest of the year at home. Progress with this child was made during the year and later speech therapy was provided at Purdue University. The child was said to have shown "remarkable" progress and although still mute, at the age of six is able to read, write and do simple arithmetic.[22]

CURRENT RESEARCH

There is currently a follow up study under way regarding infantile autism for the purpose of re-evaluating 14 children originally diagnosed as autistic at approximately the age of two years. "The specific aims are: (1) to assess the correctness of the diagnosis in terms of current psychiatric status; (2) to develop the natural history of the disease; (3) to develop reliable clinical methods of observation and judgement; (4) to assess the incidence of currently used clinical hunches pertaining to the families of such children; and (5) to re-evaluate the developmental examination to isolate the

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[22]Rosalind C. Oppenheim, "They Said Our Child Was Hopeless," The Saturday Evening Post, Vol. 234 (June 17, 1961), pp. 23, 56, 58.

diagnostic and prognostic signs which led to the initial diagnosis of infantile autism and to assess their reliability in terms of current status."[23]

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[23]Research Relating to Children. Bulletin No. 12, p. 37. "A Follow-up Study of Infantile Autism.

Chapter 5

PSYCHOPATHY

Psychopathy refers to a "paucity in the capacity to relate to other individuals, an absence or shallowness of fantasy life, and a limited capacity to experience anxiety."[1]

It is thought that psychopathic personalities may be created in a number of ways. One type is the person who spends a large portion of his first two years of life within an institution where they lack the opportunity to relate to and identify with a single person. (See Chapter 7 on Hospitalism for this form of psychopathy). Another way in which the disorder may occur is in children who are moved frequently to various boarding homes in early infancy and childhood and thus are unable to identify with any single person over a consistent period of time. Then there is the child whose parent or parental substitute has frequent mood changes in which they may change from rejecting to accepting mood swings, thereby making identification with a love object difficult or impossible.

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[1]Harry Bakwin and Ruth Morris Bakwin, "Emotional Deprivation in Infants," Clinical Management of Behavior Disorders in Children, (Philadelphis: W. B. Saunders Company, 1954), p. 367.

SYNDROME

Goldfarb observed the following results of deprivation in children who spent their first two or three years in an institution:

"1. Expressions of concept deficiency. The children had difficulty in learning songs, rhymes and stories, in grasping number concepts, in sizing up situations, in achieving time and space orientation, in recalling the past in a focused fashion and in anticipating the future.

2. Absence of normal inhibitory pattern. Overactivity and disorganization were the major symptoms. The children were enuretic and unmanageable and given to temper tantrums. They showed extreme curiosity regarding the environment, yet were unable to comprehend its meaning so that there was a constant unsatisfied drive to test and try out.

3. Affect hunger. This showed itself in an indiscriminate and insatiable demand for attention and affection. The children "never had enough."

4. Emotional imperviousness and superficiality of relationship. The demand for affection did not significantly enrich the capacity to form ties. There was a shallow, easy-going response to change of foster home or threatened removal from a home where the children had been fully accepted.

5. Absence of normal tensions and anxiety following acts of hostility, cruelty or unprovoked aggression. School failure was accepted complacently.

6. Social regression. The institution adolescents were inferior in social maturity to adolescents who had spent their infancy in foster homes."[2]

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[2]Leo Kanner, "Hospitalism," Child Psychiatry, (Springfield: Charles C. Thomas, 1948), pp. 703-704.

Goldfarb feld that extreme deprivation that is experienced by institution children apparently results in a quasi-constitutional fixation on the most primitive levels of conceptual and emotional behavior. This behavior pattern bears resemblance in many respects to that which is encountered in certain organic, and expecially postencephalitic and post-traumatic conditions.[3]

Spitz, in an investigation of motor hyperactivity observed that in hypermotile children the profile showed that there was a retardation in the social and manipulative sectors. Motor hyperactivity appeared in the form of rocking and he found a specific environmental picture created by maternal attitudes which were characterized by rapid and extreme mood swings. The mothers were found to have personalities of an infantile and psychopathic nature.[4]

It was felt that the above factors led to the creation of psychopathic personalities as there appeared to be certain personality characteristics in the children examined that were similar to those found by other investigators with older children manefested psychopathic features. For example,

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[3] Ibid.

[4] René A. Spitz, "Possibel Precursors of Psychopathy," American Journal of Orthopsychiatry, XX (1950), pp. 244-245.

Bender, in observing a group of psychopathic children observed that as a result of disturbed object relations a certain constellation of the infant personality, the social sector was retarded and there appeared to be surprisingly little anxiety.[5] Spitz thereby speculated that psychopathic tendencies were expressed in a retardation of the social and manipulative sectors and is due to the inability to establish and master social relations and interchange. The most outstanding anomaly in the psychopathic personality is his inability to form adequate social interchange and that his behavior is asocial or antisocial.[6]

The manipulative sector measured the child's ability and interest in handling adequately toys, tools, and objects. This appears to coincide with one of the main characteristics of the psychopathic child which is that of disinclination and lack of application to any task demanding a continued effort.[7]

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[5] Ibid., p. 247.

[6] Ibid., p. 245.

[7] Ibid.

ETIOLOGY

Bender stressed that psychopathy in childhood appears in children without object relationships in the first three to four years.[8] Bowlby found that the most serious form of delinquent theft developed in children who had been separated from their object.[9] Spitz found that there was a disturbed development of object relations leading to personality development which was characterized by the social maturity profile, which was thought as being a possible precursor of psychopathy. It is thought that in psychopathy there is difficulty in the formulation of adequate relationships and the incapacity to properly utilize the mechanism of identification.[10] We frequently find that with psychopaths and particularly with psychopathic children, there have been long-term separations from the mother, broken homes and lack of object relationships.[11] There are certain specific emotional factors involved which are due to the above mentioned

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[8] Ibid., p. 246.

[9] Ibid.

[10] Ibid., p. 246-247.

[11] Ibid., p. 247.

enviromentalal circumstances. However, they are not identical with these factors as the emotional factors are due to certain specific maternal personalities. One maternal personality is that which makes identification impossible by contradictory and inconsistent affects which vary with great rapidity. This sort of maternal personality can create the psychopathy even when the home remains unbroken and may explain those psychopathic personalities found in economically secure families.[12] Another possibility is where the child's environment consists of a series of rapidly changing mother substitutes, whose varying and contradictory personalities make them unpredictable, thus leading to the formation of psychopathy in the child.[13] It is believed that the rapidly changing maternal personality makes the establishment of reliable object relations impossible thereby directing the energies normally utilized to establish object relationship to remain at a more narcissistic object level, thus resulting in motor hyperactivity manifested in rocking.[14]

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[12] Ibid.

[13] Ibid.

[14] Ibid., p. 246.

DIAGNOSIS AND TREATMENT

Several treatment methods have been suggested for the young child who shows signs of being an affectionless child. Bender emphasized the value of "social patterning and providing opportunities for mirroring the behavior of others." She suggests their placement in homes providing clear-cut examples of social behavior in which the child has an opportunity to learn how to behave despite the lack of appropriate emotional response.[15]

Lowrey found that in children who spent their first two or three years in an institution and then were placed into boarding homes demonstrated personality patterns of the affectionless child. When placed into boarding homes, they were given too much freedom. The commonly recurring patterns were as follows: At first the child was thought to be "cute," his demands for affection were readily met and aggressiveness was indulged with few limits set for activity. The behavior then became more and more extravagant and the child was called "wild." Repressive tactics were begun and the child's latent hostility flared up, leading to more obvious antisocial conduct. At that point the child had to be moved

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[15]Bakwin and Bakwin, loc. cit., p. 367.

and the same cycle was repeated. It was felt that the child was exposed all at once to too many and too great changes for his level of development whichwas retarded in the social sector.[16]

It was thought that children coming from the infants home should undergo a cushioning experience of living in a small group, intimately in contact with warm adults who were genuinely interested in these children, and professionally concerned about them. Lowrey described instances of wild destructive children with markedly inadequate speech who have developed in all ways from three months to a year so that placement was possible and very successful. It was felt that children should not be transferred directly from institutions to boarding homes at three to four years of age, as this is the age at which negativism is at its peak.[17]

Emmons and Jacobucci have utilized the following methods with children who were thought to be affectionless resulting from early negative environments consisting of varying degrees of maternal deprivation: These were children being prepared

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[16]L. G. Lowrey, "Personality Distortion and Early Institutional Care," American Journal of Orthopsychiatry, X, (3, 1940), p. 279.

[17]Ibid., p. 585.

for adoptive placement. The three examples given were of a child of 2 1/2 years, of 3 1/2 years and one child of 6 years. The symptoms of the affectionless child were not immediately recognized in the first two children until their adoptive placements were about to disintegrate. The first child was tied down to his bed, thus forcing a regression to earlier infantile levels, necessitating the adoptive parents to treat him at all levels of early child development. He developed the need to be spoon-fed, talked baby talk, etc. The six year old was engaged in play therapy while the adoptive parents were being seen by another worker. After several months of treatment, the child regressed to babyhood through very infantile behavior. Once able to become dependent, the child was capable of developing the kind of emotional relationship necessary in the dependent parent-child relationship and to rebuild a healthy emotional foundation.

The third case illustrated was that of a 3 1/2 year old girl who was forced into a regressed dependency state by her adoptive parents from the beginning. Although she was able to dress and feed herself, her adoptive mother was instructed to do this for her. Although the child objected in the beginning, she soon fell into the role of recipient and eventually was completely helpless at which point she was able

to place her trust in her adoptive parents and thereby achieve an effective and successful adoption.[18]

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[18]Mary Hunt Emmons and Lousi Jacobucci, "Children Who Do Not Cry," Child Welfare, XXXIX (April, 1960), pp. 26-30.

Chapter 6

PSYCHO-TOXIC DISEASES OF INFANCY

This chapter is devoted to the classification of a number of inappropriate maternal attitudes contributing to psychotoxic diseases occuring in infancy.

It is thought that harmful psychological influences result from unsatisfactory mother-child relationships. In such cases the mother's personality seems to act as a disease provoking agent or a psychological toxia.

COMA IN NEWBORN

Coma in the newborn child is the result of over primal rejection of the mother towards her newborn child. The maternal attitude consist of the mothers' global rejection of her maternity and concurrently that of her child. It is often manefested during pregnancy, but always begins with the delivery. Margaret Ribble published an article in 1937 in which she described the reactions of newborn infants to their rejecting mothers. In the most extreme cases the infants became stuporous, fell into a comatose sleep with Cheyne-Stokes respiration, extreme pallor and dimished sensitivity. They had to be treated as in states of shock, by

saline clysis, intravenous glucose and blood transfusion. Upon recovery, they had to be taught to suck by stimulation of the mouth. If not treated early, the infants life was in danger. It was thought that even when the infants life was saved, other less severe psychosomatic consequences will appear and certain cases of vomiting of infants during the first three months of life probably also belong in this category.[1] The term "overt primal rejection" is given for this form of maternal rejection because it impinges on an infant who has not yet an opportunity to develop any method of defense or adjustment.[2]

As the child grows maternal rejection will take a different form and lead to a different result. The infant's personality will become progressively more diversified with more developed infantile personality and individual and varied maternal hostility patterns will evolve.[3]

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[1]René A. Spitz, "The Psychogenic Diseases in Infancy: An Attempt at their Etiologic Classification," The Psychoanalytic Study of the Child, Vol. VI (New York: International University Press Inc., 1950), pp. 260-261.

[2]Ibid., pp. 261-262.

[3]Ibid., p. 261.

THREE-MONTHS COLIC

Three-months Colic is thought to be the result of the maternal attitude termed as primary anxious overpermissiveness. This consists of a particular kind of overprotection during the first trimester of life.

The "three-months colic" can be described by the following clinical picture: Between the third week and the third month, the infants begin to scream in the afternoon. They are temporarily reassured by feeding. They appear to be subject to colicky pains. Changing the formula or changing from breast feeding to formula is of no avail. The stools of these infants show no pathology, although at times diarrhea may be present. The pains may go on for several hours and then subside, only to start again the next day. The time of day may vary. This condition has a tendency to disappear around three months of age.

This condition does not seem to be a problem in institutions where a child had little or no care. Some observations of children who had developed "three-months colic," indicate that in a very large percent of such cases, the condition disappeared when the infants were given a pacifier.

It has been suggested that possibly the infants' congenital hypertonicity would represent a bodily compliance, to

which the mother's overpermissiveness would have to be added to result in the "three-months colic." Such overpermissiveness would have to be added to result in the "three-months colic." Such overpermissive mothers may be more prone to develop anxiety when confronted with unpleasant manifestations of the child; that they can only deal with such unpleasure manifestations by increasing their permissiveness still more, and thus a vicious cycle may develop in which the child's cry, in reality an expression for tension release, is answered by offering food thereby increasing the tension and producing colic. This cycle is interrupted when a pacifier is introduced, since the pacifier reduces tension without interferring with the metabolic process.[4]

"INFANTILE NEURO-DERMATITIS"

The maternal attitude causing the illness called Infantile Neuro-dermatitis consists of manefest anxiety, chiefly in regard to the child and corresponds to the presence of unusually large amounts of repressed hostility on the part of the mother. This hostility becomes evident in the frequency with which the mothers' barely avoid inflicting serious injury

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[4]Ibid., pp. 262-264.

to their babies, such as feeding them with an open safety pin in the cereal, dropping the infant several times on its head, consistent intolerable overheating of the baby's cubicle, knotting the baby's bib so tight the child barely escaped strangulation, etc. These same mothers may show a curious inhibition in that they are afraid to touch their children or refused to touch them. Some mothers express this particularly in that they may always try to get others to diaper, wash or feed their children.

The children usually express the effects of this maternal attitude by manefesting infantile neuro-dermatitis or eczema. These children also showed a characteristic retardation in the area of memory and imitation. There seems to be a consistent retardation in the areas of social relations.

In the case of the eczema child, the anxiety-ridden mother avoids touching her baby because of her repressed aggression. Therefore, she makes it impossible for the child to identify with her at an age when the child's ego is still incomplete, and the mother assumes the functions of the child's ego. When this external ego withdraws psychologically because of anxiety, the child cannot develop its own ego through his identification with the mother.

This is particularly true in the second half of the first year when the personality begins to form secondary identifications. The anxiety-ridden mother offers no opportunity for secondary identification in bodily activities or a manipulative and imitative kind. Thus, the infant's libidinal and aggressive drives, normally discharged in the course of the mother's handling and converted into identifications, remain undischarged. Instead, it appears that they are discharged in the form of a skin reaction.[5]

HYPERMOTILITY (ROCKING)

The maternal attitude which oscillates rapidly between pampering and hostility appears to lead frequently to disturbed motility in the child, namely hypermotility (rocking) and hypomotility. Within the group of hypermotility the form which seems to appear in large numbers, particularly in an institutional environment is the rocking behavior of infants. It's pathological proportions were manifested in that it became the principal activity of the children affected, by substituting for most of their other normal activities, because of its frequent, striking violence which appeared

[5]Ibid., pp. 264-267.

out of proportion with the physical resources of the child. It seems to involve a much larger amount of motor behavior than is seen in the average normal child of the same age. Its phenenology consists in rocking movements, mostly in the knee-elbow position, not frequently in the supine position at earlier ages, and not infrequently in either the standing position at later ages.

Clinically these children show a characteristic retardation in the social and the manipulative areas of their personality. It is thought that rapidly changing maternal attitudes, oscillating between overpampering and extreme hostility, will impair the formation of object relations of all kinds in the psychic sphere, while resulting in hypermotility, manifested as rocking, in the physical sphere.[6]

FECAL PLAY

Fecal play in the young child is though to be due to cyclical mood swings of the mother. In this picture, the maternal attitude toward the child remains stable for several months and then changes into its opposite which also persists for several months.

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[6]Ibid., pp. 267-268.

In a study of 153 children and their mothers, 16 children were found to exhibit fecal play and coprophagia in the fourth quarter of the first year. It was found that the bulk of psychosis in the 153 mothers was concentrated on the mothers whose children manifested fecal play.

The clinical symptoms of depression with long-term mood swings were evident in mothers of the coprophagic children. The mothers attitudes toward the children would be oversolicitous for many months and then suddenly change to extreme hostility with rejection. It was felt that the reason why such an attitude resulted in coprophagia is that of the oral introjection of an "object" which occurs during the transitional period from the oral to the anal phase.[7]

AGGRESSIVE HYPERTHYMIC

The aggressive hyperthymic illness is thought to be due to consciously compensated maternal hostility. This is where the parents are more eager to use the child for their own exhibitionistic and narcissistic needs rather than as a love object. They recognize that their behavior toward their child is not proper and consciously overcompensate this with subacid syrupy sweetness.

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[7] Ibid., pp. 268-269.

It is believed that children experiencing this kind of maternal attitude stay retarded in the social area of their personality during the first year of life. while at the same time they are advanced in all other sectors. In the second year, they present a predominant picture of hostility. It is thought that in later years they will present the picture of the aggressive hyperthymic described by Dr. John Bowlby in his study of Forty-four Juvenile Thieves.[8]

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[8]Ibid., pp. 269.

Part 3

THE EFFECTS OF TOTAL DEPRIVATION

Chapter 7

HOSPITALISM

Hospitalism is a term used to define a "vitiated condition of the body due to long confinement in a hospital." This term is increasingly being used to "specify the evil effects of institutional care on infants, placed in institutions from an early age, particularly from a psychiatric point of view."[1]

It was through the efforts of Dr. Henry Dwight Chapin that there came into being the system of placing infants into boarding homes instead of leaving them in institutions.[2] Prior to this time, infants placed in hospitals and institutions were almost without exception doomed to eventual marasmus and death. Those that survived were markedly retarded and permanently deficient.

In some instances special institutions have been set up whereby more adequate care and more attention could be given

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[1] René A. Spitz, "Hospitalism: An Inquiry Into the Genesis of Psychiatric Conditions In Early Childhood," The Psychoanalytic Study of the Child, Vol. 1, (New York: International Universities Press, Inc., 1945), p. 53.

[2] Harry Bakwin and Ruth Morris Bakwin, "Emotional Deprivation in Infants," Clinical Management of Behavior Disorders in Children, (Philadelphia: W. B. Saunders Company, 1954), p. 366.

to the child, which markedly reduced the mortality rate. However, it was then discovered that institutionalized children almost without exception developed psychiatric disturbances and became asocial, delinquent, feebleminded, psychotic, or problem children.[3]

SYNDROME

The symptoms of hospitalism as described by Bakwin show the following well defined clinical picture: a striking feature seems to be their failure to gain properly in spite of the ingestion of diets which in the home may be entirely adequate. They sleep less than do infants who are at home. They rarely smile or babble spontaneously. They are listless, apathetic and appear unhappy. Their appetite is indifferent and they accept food without enthusiasm. The stools tend to be frequent and it is unusual for twenty-four hours to pass without an evacuation which is in sharp contrast with the habits of infants cared for in the home. Infections of the respiratory tract often persist for months in a hospital whereas normally they only last a day or two in the home.[4] Return home results

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[3] Spitz, loc. cit., p. 54.

[4] Harry Bakwin, "Loneliness in Infants," American Journal of Diseases in Children, 63, (1942), p. 31.

in defervescence within a few days along with a prompt and striking gain in weight.[5]

Apart from the severe developmental retardation, in the last third of the first year the reaction to strangers varied from extreme friendliness to any human partner combined with anxious avoidance of inanimate objects, to a generalized anxiety expressed in blood-curdling screams which could go on indefinitely.[6]

There are also extraordinary deviations from the normal in the time of appearance and disappearance of familar developmental patterns; and the appearance of bizarre stereotyped motor patterns distinctly reminiscent of the stereotype in catatonic motility.[7]

The restriction of psychic capacity is a progressive process and if there is no proper intervention, the developmental quotient by the end of the second year sinks to 45, which corresponds to a mental age of approximately 10 months, and would classify these children as embeciles.[8]

Children who enter an institution or hospital in infancy and remain until 2 and 3 years of age showed personality

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[5] Ibid., p. 31.

[6] Ibid., p. 31.

[7] Spitz, loc. cit., p. 72.

[8] Ibid., p. 70.

distortion to be quite marked. There are symptoms or inadequate personality development, characterized chiefly by an inability to give or receive affection and by noticeable insecurity. Behavior traits occurring frequently were hostile aggressiveness, temper tantrums (often of exceptional violence), enuresis, speech defects (sometimes amounting to near mutism) attention-demanding behavior, shyness and sensitiveness, eating difficulties (including refusal of food, fussiness and voracity), stubborness and negativism, selfishness, finger sucking and excessive crying.[9]

ETIOLOGY

It was felt that the psychological injury to institutional children was due to two factors which have been stressed by Durfee and Wolf, that of lack of stimulation and the presence or absence of the mother. It was felt that the most destitute of homes offered more mental stimulation than the usual highly sterilized and isolated hospital ward and that stimulation by the mother will always be more intensive than even the best trained nursery personnel.[10]

Spitz advances the idea that perception is a function of the libidinal cathexis and therefore the result of the

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[9] Bakwin, loc. cit., pp. 35-36.

[10] Spitz, loc. cit., pp. 54-55.

intervention of an emotion of one kind or another. These emotions are provided for the infant through the intervention of the mother or her substitute and a progressive development of emotional interchange with her provides the child with the perceptive experiences of its environment. The child learns to grasp at the mother's breast thereby combining the emotional satisfactions with tactile perceptions. He learns to distinguish animate objects from inanimate ones by observing his mother's face in situations full of emotional satisfactions. It is through the emotional experiences of mother and child that he learns to play and becomes acquainted with his environment as the mother carries him around. In this way he learns security in moving around and this security is reinforced by her response to him when he calls. He is thereby stimulated to learn and later imitate. It has been observed that when the above is lacking that even children of two or three years are unable to walk. It was felt that children suffer deprivation when their perceptual world is lacking human companions and that isolation cuts them off from stimulation from those who could signify mother-representatives for the child during the first year. The result is a complete restriction of psychic capacity by the end of the first year.[11] This restriction is

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[11] Ibid., pp. 67-70.

a progressive one and if the child is not removed from the institution at the end of the first year it is felt he can become permanently mentally deficient and there is no known treatment method to reverse this process beyond a certain point.

PROGNOSIS AND TREATMENT

Although in the hospital or institution the child is subject to respiratory infections and inability to gain weight, return home or placement into foster care results in marked improvement within a few days along with a striking gain in weight.[12]

Normal infants as young as three months smile and become animated in response to the pleasant expressions from others. However, it is difficult to elicit a response even for a short period from infants who have been in a hospital for any length of time. Only after repeated attempts have been made does a response occur. It is thought that psychologic neglect leads to a dulling of the reactivity of the child to emotional stimuli.[13]

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[12] Bakwin, loc. cit., p. 31.

[13] Ibid., p. 34.

The physical picture of the institutional child is that of children half their age, (that of marked retardation).[14] Spitz found that children who were deprived of maternal care, stimulation and love as well as complete isolation suffered irreparable damage. A number of children suffering from this form of serious maternal deprivation after fifteen months, were placed into very favorable environment where they were provided with very active stimulation. In spite of this improvement, the deterioration process continued to progress. It seemed that the developmental imbalance caused by the unfavorable environmental conditions during the children's first year produced a psychosomatic damage that cannot be repaired by normal measures. Repair by therapeutic methods remains to be explored.[15]

Some authorities such as Durfee and Wolf have found that children under three months seem to show no demonstrable impairment as a result of institutionalization. However, children who had been institutionalized for more than eight months during their first year show such severe psychiatric

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[14]René A. Spitz, "Hospitalism: A Follow Up Report," The Psychoanalytic Study of the Child, Vol. II, (New York: International Universities Press, Inc., 1946), p. 115.

[15]Ibid., pp. 115-116.

disturbances as to make testing impossible.[16] Bender, Goldfarb and Lowrey found that the changes which occurred after three years of institutionalization are irreversible.[17] Lowrey found, however, that the impaired functioning of children hospitalized in the second and third year can be corrected.[18] When the child was prepared for transfer to a foster home he underwent a period of preparation in which he was first placed into a center where he had the experience of living with a small group, in close contact with warm adults having a professional concern about them. After a period of time within this arrangement, the child was placed into a boarding home. (See Chapter 5).[19]

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[16] Spitz, "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," The Psychoanalytic Study of the Child, Vol. I, (New York: International Universities Press, Inc., 1945), p. 54.

[17] Ibid.

[18] Ibid.

[19] L. G. Lowrey, "Personality Distortion and Early Institutional Care," American Journal of Orthopsychiatry, X, (3, 1940), p. 279.

Chapter 8

ANACLITIC DEPRESSION

Anaclitic depression is a term coined by Spitz and Wolf to describe a type of severe depression experienced by infants upon the separation from/or the loss of a love object, usually the mother with whom the child has become closely identified. This type of a severe depression usually occurs from the sixth to the eighth month.

The most notable work dealing with anaclitic depression in the infant was a study by René Spitz in collaboration with Katherine Wolf regarding their observations of 123 unselected infants within a nursery.[1] A few of these infants who entered the nursery as happy and outgoing youngsters later developed a very markedly different behavior in the form of weepiness and then withdrawal from the enviornment.

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[1] René A. Spitz and Katherine M. Wolf, "Anaclitic Depression - An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," The Psychoanalytic Study of the Child, Vol. II (New York: International University Press, Inc., 1946), pp. 313-342.

SYNDROME

The symptoms of anaclitic depression fall into several categories. Within each category symptoms are grouped on a scale with increasing severity. They are:

> Apprehension, sadness, weepiness.
> Lack of contact, rejection of environment, withdrawal.
> Retardation of development, retardation of reaction to stimulation, slowness of movement, dejection, stupor.
> Loss of appetite, refusal to eat, loss of weight.
> Insomnia.

There is also a physiognomic expression which is difficult to describe but is comparable to that of depression in the adult.[2]

The progression of symptoms according to periods of time is as follows:

> "First month: increased demandingness and weepiness.
> Second month: refusal of contact, pathognomonic position (lying prone with averted face), insomnia, further loss of weight, intercurrent ailments, restriction of motility becomes generalized, facial expression rigid.
> After the third month: rigidity of facial expression becomes stabilized, weepiness subsides, retardation and lethargy.[3]

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[2] Ibid., p. 316.

[3] René A. Spitz, "The Psychologanic Diseases in Infancy: An Attempt at Their Etiologic Classification," The Psychoanalytic Study of the Child (New York: International Universities Press Inc., 1950) VI, p. 270.

If the mother returns to the child or an adequate substitute is provided during the critical period of three to five months the condition improves with surprising rapidity.[4]

ETIOLOGY

The factors which were present in anaclitic depression in the infants studied showed that the syndrome became manifested around the turn of the sixth month. The oldest of the series studied by Spitz and Wolf was around the eleventh month.[5]

It was felt that the developmental age and level of intelligence did not play a significant role in the formulation of the syndrome of anaclitic depression.[6] The most significant factor in the development of the syndrome was that of the removal of the mother from the child somewhere between the sixth and eighth month for a practically unbroken period of three months, during which time the child either did not see its mother at all or saw her only once a week. The separation occurred for unavoidable external reasons. Before

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[4] Ibid.

[5] Spitz and Wolf, loc. cit., pp. 318-319.

[6] Ibid.

separation, the mother had the full care of the infant, and as a result of special circumstances spent more time with the child than usual. In each case there was a striking change in the child's behavior in the course of from four to six weeks following the mother's removal and the very distinct syndrome would develop. It was felt that this syndrome develops only in children who are deprived of their love object for an appreciable period of time during their first year of life. The intensity of the depression seems to be related to the intensity of emotional relationship existing between the mother and child. That is, the more intense the mother-child relationship, the more intense was the depression. A less intense relationship will result in a milder form of depression as a result of maternal deprivation.[7]

The reactions to the loss of love object in the infant is considered similar to the descriptions given to us by Abraham and Freud of mourning, pathological mourning, and malancholia. In malancholia there is a feeling of being unloved, along with an incapacity to love, self-reproach, and suicidal tendencies. It is thought that the different way in which the infant may attempt suicide is due to the more

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[7]Ibid., pp. 319-320.

limited physical and psychical capacities of the infant. Therefore, the suicidal attempts of the infant are demonstrated through their greater susceptibility to illness and in the absence of proper intervention on into marasmus and eventual death.[8]

DIAGNOSIS, PROGNOSIS AND TREATMENT

The diagnostic signs and symptoms of anaclitic depression fall into groupings of static, genetic, and quantitative ones. They are as follows:

1. Static signs and symptoms.

Those observable phenomena that can be ascertained in the course of one or several observations of the infant in question. One outstanding sign is the physiognomic expression. One at once notices an apprehensive or sad or depressed expression on the child's face, which may impel the observer to ask if the child is ill. In this stage it is characteristic that the child make an active attempt to catch the observer's attention and to involve him in a game. However, this outgoing introduction is not followed by particularly active play on the part of the child. It is acted out in

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[8]Ibid.

the form of clinging to the observer and sorrowful disappointment at the observer's withdrawal.

In the next stage the apprehensiveness deepens. The observer's approach provokes crying or screaming, and the observer's departure does not evoke as universal a disappointment as was the case previously. Many of the cases observed fell into the "eight months anxiety" period which begins between the sixth and eighth month and is a product of the infants increasing capacity for diacritic discrimination between friend and stranger. Therefore, an approaching stranger is received either by "coy" or "bashful" behavior, or by the child's turning away, hanging its head, crying, and even screaming in the presence of a stranger, refusing to play with him or to accept toys. In anaclitic depression, it takes up to an hour to achieve contact with the child and to get it to play, in the eight-month's anxiety this contact can be achieved with the help of appropriate behavior in a span of time ranging from one to ten minutes. The appropriate behavior consists in sitting down next to the child's cot with one's back turned to him and without paying any attention to him. After a period of from one to ten minutes the child will grab the observer's gown or hand and contact is established and an experienced child psychologist can lead from

this into playing with the child's active and happy participation. Nothing of this sort occurs in anaclitic depression. The child does not touch the observer and the approach has to be moderately active on the observers part, and consists mostly in patient waiting, untiringly repeated attempts at cuddling or petting the child, and incessant offers of constantly varied toys. The toys must be offered with a capacity to understand the nature of the child's refusal.

When contact is finally made the pathognomonic expression does not brighten. After accepting the observer the child plays without any expression of happiness. He does not play actively and is severely retarded in all his behavior manifestations. The only signs of his having achieved contact is his acceptance of toys and his expression of grief and crying when left by the observer.

In the following stage the outward appearance of the child is that of complete withdrawal, dejection and turning away from the environment.[9]

2. The genetic signs.

Before the above attitudes set in, the child was known to be a pleasant, smiling, and friendly baby.

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[9] Ibid., pp. 327-328.

3. Quantitative signs.

The quantitative signs can be detected by consecutive developmental tests which, if compared to each other, will at the beginning of the anaclitic depression show a gradual drop of the developmental quotient. This declining mental quotient progresses with the progression of the disorder.[10]

Prognosis With Intervention:

The intervening measure used was in the nature of environmental manipulation which consisted in returning the mother to the child. The change in the childrens observable behavior was dramatic. They were suddenly friendly, gay, and approachable. The withdrawal, disinterest, rejection of the outside world, and sadness disappeared instantly. The most striking change was the jump in the developmental quotient, within a period of twelve hours after the mothers return. In some cases the developmental quotient was as much as 36.2 per cent higher than the previous measurement.

It was thought that the psychic trauma sustained by these children as a consequence of being separated from their mother's will leave traces which will become visible later in life. The sudden astonishing jump in the developmental quotient on return of the love object was not

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[10] Ibid.

maintained in all cases. It was observed that in some cases in which, after a period of two weeks, the developmental quotient dropped again. It did not drop to the levels reached during the depression, however, compared to these child's pre-depression performance, the level on which they were functioning after their recovery was not adequate.[11]

Prognosis Without Intervention:

It has been observed that when the love object is not restored in those children experiencing anaclitic depression that there were additional developments taking place. The condition of the children in advanced extreme cases varied from stuporous deteriorated catatonic to agitated idiocy. This syndrome is of a progressive nature which after having reached a critical point of development seems to become irreversible. It is this characteristic which caused Spitz and Wolf to call this picture depression and not mourning. Beyond this point the rate of mortality was inordantly high, and many die of diseases varying from respiratory and intestinal infections to measles and otitis media. In some instances death was in the nature of cachexia, a phenomena that savors of psychosomatic involvement.[12]

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[11] Ibid., p. 330.

[12] Ibid., pp. 330-331.

No intervention was effective when separation lasted over a number of months. Three months of separation was considered to be the critical period. It was observed that towards the end of the three months there developed the appearance of a kind of frozen, affect-impoverished expression. A curious reluctance to touch objects was manifested, combined with certain unusual postures of hands and fingers which seemed to be the precursors of the extremely bizarre hand and finger movements composing the total activity similar to infants reared in institutions presenting a picture of stuporous catatonia.[13]

Treatment:

The effective therapeutic measures which applied were prophylaxis, restitution, and substitution. 1) Prophylaxis: infantile deprivation of love objects for prolonged periods during the first year of life should be avoided. They should not be deprived for longer than three months during the second half of the first year. 2) Restitution: if deprivation for a prolonged period during the first year does occur, restoration of the love objects within a maximum period of time will enable the child to recover, at least partially, from

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[13]Ibid., p. 331.

the damage inflicted. 3) Substitution: where neither prophylaxis nor restitution is possible, the substitution of another love object is advisable. Special attention should be given to the facilitation of the infants locomotor drives in the largest measure possible, and to the supporting of its tendencies to choose actively its own substitutes for the lost love object.[14]

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[14] Ibid., pp. 338-339.

Part 4

SUMMARY AND IMPLICATIONS

Chapter 9

SUMMARY AND DISCUSSION

This study has been devoted to a review of the available literature describing the effects on social functioning of maternally prived and deprived children. An attempt has been made to sort out and arrange the material into specific clinical pictures with a study of the causes, prognosis and treatment methods currently known. Hopefully this study will operate as a basis for further research and study in future efforts to refine and develop treatment solutions of emotional illnesses and disturbances of early childhood and subsequently to a better understanding of mental diseases of later life.

A summary of the material collected seems to show that much of pregnancy with its psychological elements which evolve out of the biological changes represents preparation and preconditioning for motherhood. The relation of the mother to her offspring seems to be an extension of her acquired concept of and relationship to herself.

It is considered significant that two of the clinical pictures which show serious and devastating effects on the child are that of symbiotic infantile psychosis and coma in the newborn. A closer look at the syndromes will differentiate

the degree and kind of effects. In both instances the mother shows rejection of her maternity and of sexuality and hence of the child. However, the kinds and intensity of rejection seems to vary. The mother of the child manefesting coma in the newborn, totally rejects her maternity and extends this to total rejection of her child which in turn becomes a serious toxic to the infant shortly after birth. Due to the child's lack of opportunity to have developed any sort of defences, he has no recourse but to go into a state of shock and coma.

The mother of the symbiotic child seems to manefest extremely ambivalent feelings towards the child which may include disgust and rejection of close contact with the infant such as touching, cleaning, rubbing, holding, and fondling a product of sexual activity. Yet she expresses very anxious oversolicitousness in which she denies the child the right to demand. She thus undermines his potential ability to control his own inner tensions, leading to an early enhancement of a very pathological dependency upon her. This combination of rejection and pathological clinging to the child may in part account for the childs behavior. As he makes efforts to develop his own independence he fears he cannot risk being separated from the symbiotic adult partner. This

may also be the reason for the extreme ambivalence of the child in which he will concurrently show completely confused manifestations of love and aggression in impulse-ridden behavior.

Much of the material collected has not been able to pin point specific causes of illness thus pointing up the need for a great deal more research of the effects of maternal deprivation. There is still lack of clarity as to "why" and the "what" that certain mothers contribute to certain illnesses. For example, in the literature discussion of psychopathy, aggressive hyperthymic, infantile neuro-dermatitis, three months colic, fecal play, early infantile autism, symbiotic infantile psychosis, maternal attitudes such as physical and/or psychological withdrawal, coupled with over-soclicitousness, a basic inability to accept or love the child, deep feelings of ambivalence, pervasive and chronic anxiety, marked inconsistency, impulsiveness, etc., appear with regularity as component elements in the maternal behavior towards the newborn and infant. Likewise the overlapping in the symptoms of the child makes differential diagnosis difficult. Hence, one can safely say that at this time it is not possible to chart a cause and effect relationship between specific maternal attitudes and specific

response patterns in the newborn and infant. Further research into the nature of the composition of maternal attitudes and their effect upon the child is necessary before predictions regarding the behavioral response patterns of the child may be attempted.

Severe character disorders such as sociopathy or psychopathy seem related to the physical and/or psychological loss of the parent which without adequate compensation, or to a traumatizing disappointment in the parent, leads to an overt delinquent patterning in the child. The impersonal institutional care to which the infant may be subjected for long periods of time may also lead to severe character disorders such as psychopathy. Severe forms of maternal over-protection for whatever motivation tend to be associated with very early psycho-sexual fixation, coupled with a predisposition towards psychosomatic illness, apathy and withdrawal, disturbed motility, retardation in social and manipulative skills, which in turn leads to narcissistic object relationships.

In one of the clearest clinical examples so far obtained, that of early infantile autism, very specific factors are discussed in the literature in describing the kinds of parents that such children have as well as a clear cluster of symptoms to be found in the children themselves. However,

as we have discussed earlier, no one has attempted to correlate specific effects with specific causes and therefore there remains a lack of clarity as to specific causal factors of this particular form of illness in these particular children. The significant and interesting factor is that it does not occur in more than one family member except in cases of identical twins which poses certain questions. One of the most striking things about this particular disease is that it is the only syndrome in which there is no evidence of the condition being in any way associated with any injury, illness, congenital abnormality, or allergic manifestations. Although there may be every indication that these children are of average or superior intelligence in spite of that it is almost impossible to administer psychological examinations with any satisfactory results, there is a serious lack of integrated behavior resulting in distorted language, lack of social responsiveness and a lack of adaptibility to the environment. One particular feature of the parents is that very few of them seem to be warm-hearted people and for the most part seem limited in genuine interest in people. The child seems to strongly resist any close relationship with people and to be unable to distinguish between inanimate objects and people. The material

at hand in regard to child development suggests that it is through a rich emotional mother-child relationship that potentialities for emotional, intellectual, and social growth receive their opportunities for development.

Early infantile autism is to be contrasted and compared with its opposite, that of symbiotic infantile psychosis. The latter seriously binds the child to the parent figure (usually the mother or mother substitute) in a very distorted and confused fashion. One significant factor about these two syndromes is that early infantile autism becomes manifest during the first two years whereas symbiotic infantile psychosis does not become evident until between 2 1/2 and 5 years with peak onset at 4 years of age. Also, that whereas autism is unassociated with illness or pain, there may be evidence of early and prolonged illness and/or pain in the symbiotic infantile psychotic child. This latter symptom may possibly have created a need for some anxious oversolicitousness in the parent that led to a greater dependency by the child upon the parent. This illness and/or pain factor may also be somewhat explanatory for the childs preoccupation with a particular portion of his body and a factor leading to the fragmentation of the ego and fear of bodily destruction. One important factor regarding the

matter of differentiation between these two diseases is that when children manifesting these particular syndromes are observed around six or seven years or older, it is seldom that a clearly defined syndrome as those described will be apparent. Rather, there is likely to be a mixed clinical picture. It is important for purposes of making a treatment plan that a differential diagnosis be made, as essentially different treatment methods are necessary. This differentiation can be obtained by examining the history of the early years. The primarily autistic child will need to be "lured" into a relationship with the therapist and ultimately help given him to accept the need to become dependent and to develop object relationships. In the case of the primarily symbiotic child, the therapist may begin to establish an immediate relationship with the child which will be a pathological relationship similar to the kind of a relationship that the child has with the parent and then will gradually move toward a more healthy dependency relationship which essentially fosters independence.[1]

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[1]Margaret Mahler, Psycholanalytic Study of the Child, Vol. VII, 1952, pp. 286-305.

Chapter 10

THE IMPLICATIONS FOR SOCIAL WORK

I have attempted to collect and formulate readily definable clinical pictures of emotional disorders of early childhood which are believed to be rooted in early maternal deprivation. This material should be of value to those concerned with the care of children by enabling them to early recognition, treatment, and prevention of these emotional disorders according to the currently available knowledge. The implications inherent in the results of this study should be of usefulness to the child welfare field in particular.

In the first chapter concerning maternal preconditioning during pregnancy, we see how the pregnant woman undergoes emotional, physical, and social change which is in preparation for motherhood. The way in which she perceives herself during this experience, which in turn is preconditioned to some extent by prior childhood experiences and training, in part by her relationship with the child's father, and the extent to which she is able to accept these changes and mature through them will have profound effects upon the early mother-infant relationship.

The importance of providing the expectant mother with supportive social services to assist her through these profound changes of conflict solutions and adjustments occuring during this period is also important. According to Grete Bibring, of concern at the present time is that of the supportive social mechanisms which were previously provided through carefully worked out traditional customs, are now rapidly disappearing within civilized society. This causes greater stress to the expectant mother of the present era who still faces the crisis of pregnancy with fewer supportive services to assist her through this period. Therefore, some attention should be directed towards devising some substitute mechansim and/or services which will ease this crisis and provide the emotional support with whatever feelings of helplessness and frustration she might have during this period. Focusing upon the supportive role that the family plays and making available social casework services when the natural family is absent or where there is special stress such as in cases involving deserting fathers and/or unwed mothers, may provide the expectant mother with the substitute relationship necessary to her well being.

In gathering social information on developmental history in cases concerned with troubled children, social workers should explore family relationships, particularly as they effect the mother, during the pregnancy rather than emphasize

concern chiefly with her physical condition, as these experiences, both consciously and unconsciously influence the maternal attitudes toward the child.

Chapter two points out that the child needs to feel he is an important and valued love object, and the mother needs to feel that she also, is an important and valued love object to her child. Within this kind of a relationship, the mother is secure enough to free the child for gradual physical and emotional independence.

There are indications that a rich emotional experience between infant and mother is the major factor that leads to an integration of the childs instinctual, intellectual, and psychological development and thus influences behavior patterns that lead to adequate social functioning. When a mutually unsatisfactory mother-child relationship exists, there appears to develop inadequate and uncoordinated behavior and personality patterns which lead to immature and inadequate social functioning.

During the first year of life the infant's ego is most deeply sensitive and vulnerable to the impacts of internal and external stress. This points up the need to focus on the mothers behavior towards herself and her child during this period. There is a particular need for guidance and

supportive casework for anxious mothers. One possibility would be employing child welfare workers in such strategic areas as well-baby clinics and pediatricians offices in an effort to reach a large segment of the population on a preventive basis.

In our work with parents, we should educate ourselves to a greater awareness and recognition of pathological parent-child relationships and to assess the depth of the pathology. In cases where parents cannot be helped or are extremely limited in their ability to provide a healthy environment for their children, such as may be the case in a severe symbiotic infantile psychotic child or the syndrome described in chapter six on coma in the new-born, perhaps we should seriously consider directing supportive casework around assisting the parents to release their child for temporary placement, or where the possibility for parental change is absent to adoptive planning.

Although no one has attempted to relate cause and effect in the early infantile autistic syndrome, this picture does seem to suggest that parents who lacked warmth and genuine interest in others may develop an emotionally detached child which seems to show that this kind of a lack of maternal gratification or lack of emotional exchange between parent and

child produces children who are seriously handicapped in their social functioning. This absence also leads to the lack of integrated behavior and underdevelopment of intelligence which seems to be a characteristic of these children thus giving the appearance of mental deficiency even though they may actually have superior intelligence.

Chapter five on psychopathy points up the importance of controlled giving both emotionally and materially to the emotionally starved or deprived child. Just as a person without food over a period of time develops a state of physical starvation and becomes unable to tolerate solid food so too must the individual in a state of emotional starvation be given a simple and well-controlled emotional diet until his emotional system gradually develops a better tolerance for personal relationships while at the same time lessening the emotional controls.

I question whether hospital or institutional care over a prolonged period of time for a very small child or infant is necessary any more. With the increasing popularity of adoption and temporary foster care, there should be less reason to permit a child to remain in an institution for prolonged periods of time. Even with a better quality of care now provided for institutionalized infants, there is still

serious damage to personality formation which becomes apparent in children who are institutionalized in early infancy.

Anaclitic depression seems to substantiate the hypothesis that individuals whose social functioning is regarded as adequate would have had a greater amount of maternal gratification during their infancy. These children had excellent or above average parent-child relationships prior to entering the hospital and were happy and outgoing children, who, once deprived of their object relationship developed very markedly different behavior which, when continued indefinitely progressed to severe mental deficiency and eventually death.

This syndrome has implications for the adoption worker as it suggests the importance of placing the child into a permanent home within the first six months before the child has identified with its maternal substitute, a process which if interfered with or interrupted, will make the adjustment to the change of mothers more difficult for the child when he is placed at a later time during this period.

Anaclitic depression points up the need for provisions whereby the mother or her substitute may be permitted to remain with the child or will be able to visit frequently and perhaps to actively participate in the care of the child when treatment in a hospital in the early years becomes

necessary. In cases where the presence of the mother cannot be maintained or separation from the parent occurs for unavoidable reasons, the child should be kept in the hospital or institution for as short a time as possible and restoration of the parent or a good parental substitute should be made as early as possible.[1] For children coming to the attention of institutions for the mentally retarded or mentally deficient, social workers should become alert in gathering social history data which may indicate environmental circumstances as being a possible cause where children may have been misdiagnosed. A careful study should be given to the length of time and the extent to which the deterioration process has been in effect. If a picture of pseudo-retardation seems a possibility a treatment plan could be formulated with the focus placed upon reversing the deterioration process. Some plan could include a very sensitive and motherly retarded woman patient who could devote time and effort to the child, who, after a period of progress, may be transferred into a stable and warm foster family.

In all of these syndromes there appears to be some correlation between the type and degree of the adequacy of

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[1]James Robertson, Young Children in Hospitals (New York: Basic Books, Inc., 1959).

social functioning to the kind and degree of adequacy of maternal gratification, particularly as it covers the first year of life when the infant is most vulnerable and the ego defenses are least developed. The earlier and more serious the maternal deprivation occurred, the more serious appeared to be the manifestations of pathology in the individuals ability to tolerate and handle stress and the more devastating the effects seemed to be. This points up the need for the social work and allied professions to focus upon the first year and the need for a healthy and secure beginning. This not only increases the degree of social functioning but also the extent to which later mental disease process can be reversed or minimized.

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