Master of Social Work
Maritime School of Social Work

ABSTRACT

RELATIONSHIP BETWEEN MALFUNCTION
IN CHILDREN AND MALFUNCTION
IN THEIR PARENTS

by

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This research project consisted of the study of 119 children between the ages of three and sixteen. These children showed some symptoms of emotional malfunctioning. Another 102 records were disregarded after a preliminary study which revealed that they were not pertinent to this study. In all, 221 children were considered, this number being the total of children seen at The Halifax Mental Health Clinic for Children during the calendar year 1960.

The main focus of this study consisted of assessing the relationship between the child's disturbance and some pathological influence from parents and/or guardians.

This relationship proved to be insignificant with these children. Previous studies, though, had revealed that parental pathology was a component in this.

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THE MARITIME SCHOOL OF SOCIAL WORK

RELATIONSHIP BETWEEN MALFUNCTION IN CHILDREN AND MALFUNCTION IN THEIR PARENTS

A study to establish the relationship between malfunction in children and gross symptomatology in parents.

A Thesis

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by

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CHAPTER I

INTRODUCTION

European-American culture attaches a great deal of importance on parent-child relationship: the individual is generally not on his own until he is well into his adolescent stage. This way of life has its advantages and disadvantages. The child is led very slowly into a stage of independence; and this he acquires through a phase of relatively harsh discipline. Discipline creates problems in either extreme of application: if too strict discipline is administered, he will rebel against authority either overtly or by flight; while if the child is given too much freedom at too early an age, he will run against the norms of society and will not meet the expectations of the average parents. Because of these extremes in parental discipline, which in our society amounts to parental malfunctioning, there are many children who are emotionally dis-

turbed.

The problem in this study concerned the malfunction of children as related to some malfunction in the parent figures; this disturbance being obvious in at least one parent at the time of referral or having been acute at some previous stage in their life when the disturbed child needed parental support.

The working hypothesis is as follows: disturbance in parents (or parent figures) is a contributive factor in child disturbance.

No individual can ever hope to live in complete isolation: a child's emotional problem is a reflection on his family group or his environment. Children with organic brain defects or with mental deficiency do not fall into this category.

Children with every kind of pathology have been studied from the files of the Halifax Mental Health Climic for Children. Their diagnosis was generally well spelled out in the psychiatric assessment. But the diagnosis of the parents was not so clear, although it could be partly assessed

from the psychiatrist's, the psychologist's, or the social worker's observation notes.

One of the basic theoretical approaches of this project was as follows: that children react to their parents' behaviour and emotional make-up through identification, counter-identification, passive adjustment, aggressive adjustment, or some other forms of psychic reactions to parental attitudes. The individual comes into the world totally unprepared to cope with the necessities of everyday living; he has to rely on somebody for his physical maintenance and acquires his emotional maturity with the process mentioned above.

The major concepts of this study are: psychopathology, psychodynamics, psychogenetics, psychology, and a diagnostic classification. These concepts will be a basis for a theoretical formulation covering the child's total personality and behavior patterns.

This project is of a probative nature. It is based on a theoretical approach which is subse-

quently tested with files of children who were offered treatment at the Halifax Mental Health Clinic for Children during the calender year 1960. Two hundred and thirteen files were processed. The diagnostic value of these files was proportionate to the number of appointments the child or his guardians had with members of the team: the psychiatrist, the psychologist, and the social worker.

It can be assumed, for the purpose of this study, that the policies and standards of the Clinic, and the skill of the therapists in diagnostic assessment are at a level equivalent to other clinics with the same treatment program. Even if these assumptions were not correct, they would not be considered as limitations to the study because diagnoses are very much standardized, more so than treatment processes. Another limitation is one of reality: the researcher, due to the short time allowed in writing this thesis, did not have the time to go to lengthy and ac-

curate procedures to prove the diagnosis of children and the symptomatology of the parents.

The files studied at the Halifax Mental Health Clinic for Children represented a population and not a sample population, because all the cases referred during a certain time period were studied.

The presentation of this research project is in the form of a thesis. There are five chapters: (1) introduction; (2) the normal personality of the child; (3) the theoretical background; (4) study design and findings; (5) conclusions and recommendations.

CHAPTER II

THE NORMAL PERSONALITY OF THE CHILD

Throughout the developmental years, the child is dependent on one aspect or another in his environment for his psychological growth. Of course the adult's actions and attitudes always show a relatively strong component of dependence also, because "no man is an island". However dependence is much more an indispensable aspect during the formative years; in our culture this usually means through the teens; most psychologists, sociologists, and social scientists agree.

How many factors influence the child's psychological growth? The family appears to be the most influential agent. And the members of the family have various degrees of influence, depending on their respective roles; the mother generally is the most relevant person, especially with younger children, followed by the father, the older siblings, and the younger siblings in that

order. Depending on the immediacy of contact, some social psychologists would include grandparents, but this would mean going away from the nuclear family, although these relatives or others may have a bearing influence on the children.

And the logical extension of the family is the community in which the child lives and the subcultural group to which he may belong. The influence of these elements must not be brushed aside. The environment must be considered as one of the factors influencing the child's individuality.

The family and the environment outside the family constitute the two basic elements of nurture, which influence the individual by a process of conditioning and learning, through experience. The psychologist says that the individual is also dependent upon his nature to a large degree. How much of 'nature' and how much of 'nurture' drive the person to action, no one knows; there seems to be a combination of the two, in fact

this is certain.

This chapter will cover briefly the development of personality.

> The infancy of the human species has been prolonged and its plasticity has been greatly augmented; but the new-born baby does not by any means start from scratch. He is at birth already in possession of all the nerve cells he will ever have. These cells have much capacity for learning;...[1]

> This is the paradox of all growth - the baby remains himself despite the fact that he is constantly changing......This is because he has a distinctive way of developing which denotes the essence of his individuality.[2]

Gesell and Ilg refer here to basic facts of human life. The neonate has almost all to learn. During the latter part of the fetal period, it is believed that the unborn infant develops psychically: anyhow, in the uterus, the neonate receives oxygen, water, and food through the umbilical

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1/Arnold Gesell & Frances L. Ilg, INFANT AND CHILD IN THE CULTURE OF TODAY, Harper & Bros. Publishers, New York, 1943, p.13.

2/*Ibid*, p.15.

cord into his bloodstream. And since he possesses all his nerve cells at birth, his psychic development must start before this time.

However, environmental stimuli during the uterine life is very limited, so it would seem that development is limited proportionately. But the germinal period must not be forgotten in understanding the neonate's reactions. Abnormalities or injuries like pre-natal and birth traumas may be presumed to have sometimes lasting and sometimes serious effects on the individual, though the results may understandably not be attributed to such causes. Whether uterine life is important or not psychologically, is of no immediate concern to this study; the significant aspect is to remember that the individual's development becomes psychologically comprehensible as the individual grows. And the individual grows in two ways; with maturation which is the continuation of heredity, and through learning.

Now that some consideration has been given

to the pre-natal period and to some general principles, the next step consists of considering the starting point of man's psychological development. Man's first psychological attempts are characterized by drives and urges to action, and by a vast capacity to learn. The course of development involves a continual interplay between differentiation and integration: the initial drives become differentiated into particular expressions or objects; integration, on the other hand, occurs later and is somewhat more complex because the individual has to form a gradation out of the variety of differentiations he has been accustomed to, i.e. he has to make a workable way of life for himself, through an integrated form of differentiated tendencies which vary with each individual because of innate strengths and abilities. Constitutional and temperamental factors differ in individuals. But every person must abide by some basic rules if he wants to develop and socialize; he must cultivate an aptitude to

change and to persist. This may seem paradoxical, but it is clear that some situations require change for personal psychological adjustment and conformity to norms of culture; on the other hand some situations require persistence although these situations may seem monotonous and dreary. And the child must realize these difficulties and adjust himself accordingly, if he wants to experience healthy adjustment in adult life.

To explain the multiple tendencies of early childhood, Freud proposed his "libido theory"; he came to the conclusion that the libido, or the pleasure principle, permeates the early stages of psychological development. And Freud's classification of stages has been accepted as standard. The stages of libidinal organization are: approximately the first year of the child's life corresponds to the oral stage when the infant's activity centers around his mouth; the anal stage spans essentially the second and third years when anal functions are most important to the child; and

during more or less the fourth and fifth years the child is in the genital or phallic stage.

To complete the enumeration of the phases of psychological development, two more stages can be added: the latency period which includes children from six to twelve approximately, and the puberty period from twelve years up. The individual has not yet attained maturity with the achievement of all his adolescent features, but this constitutes a complete enough classification for this study.

As development proceeds the child soon becomes aware of, and eventually responsive to the demands of his environment, which is necessary if he is to learn to fit himself into his society. For the sociologist, socialization of the child is taking place; for the psychologist, the child is developing a super-ego: incorporating the usages and mores of his society, as interpreted by his family, so that he can live in that society. The individual has then mas-

tered the integration of his personality.

Family membership and social roles are two basic aspects of the environment of the child.

> The family remains the most fundamental unit of modern culture. It has been basic throughout the long history of man. The family is both a biological and a cultural group.1/

The basic importance of the family in a child's life has been demonstrated by the sociologist. The child needs his parents for biological survival first, and then gradually he needs their assistance for psychological growth. The primary family constellation consists of one male and one female, both adults, with a child. However some children develop harmoniously with the immediate supervision of only one parent, but it seems that in most of these cases the child has been able to find one or more adults of the missing sex to identify with.

1/*Ibid*, p.9.

The child's first reaction to the family group is a very passive one. As a neonate he lives in total dependence; he sleeps most of the time, waking up only to be fed by his mother. Sleep and food satisfy him totally; of course he needs love and care, otherwise he will be affected by deprivation.

Dependence gradually gives way to independence as the child grows. The child seems to cherish dependence at first, but he probably enjoys autonomy even more. The child's autonomy consists of unconcern and even apathy toward conformity to the diverse regulations that society will place upon him later. But as with dependency, the child will gradually have to give up his autonomy, which will mean giving up his childhood freedom and selfish behaving. Toilet training is one of the milestones in relinquishing autonomy and a cause of a lot of frustration for both child and parent.

Still almost entirely within the family

circle, the child's erotic or sexual interests (Freud's connotation) come into play: this occurs around the fourth or fifth year, and would likely continue on through the so-called 'latency' period if our culture did not impose limits on the child. The genital period which is referred to here, marks also the inception and apparent solution of the Oedipus and Electra complexes which may become very strong in some children. Mature family participation and insight will give added strengh to the child's own natural growth in solving it.

The child also relies on his family a great deal during his first school years. But the active participation in peer groups takes the child gradually away from his parent's view, and thus somewhat releases the family circle. Although it may seem paradoxical, the child may be deprived of parental care during this period which is more important than society tends to profess.

> ....in this so-called latent, quiescent period when nothing much is supposed to be happening and the children are "just attending school".....important situations and events occur which, if understood, can be made to be contributions to the child's personality, and which he can use to merge with what has gone before and with what is yet to come. If the events of this period are not understood or are neglected, they can leave a weakness in the personality which is corrected with great difficulty later in life.1/

Although the child gradually leaves the home and participates more and more in the community life during his adolescence, his family life stands as an important factor in the adolescent's growth. The child needs firmness and control from his parents, but at the same time emancipation must be granted by the parents and accepted as such by the child. "Emancipation, positively carried out, is one of the great contributions to maturity".2/ It allows the individual

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1/O. Spurgeon English & Gerald H.J. Pearson, EMOTIONAL PROBLEMS OF LIVING, W.W. Norton & Company, Inc., New York, 1955, (2nd ed.), p.162.

2/*Ibid*, p.344.

to accept life's problems and realities, and fit them into his own personality patterns. But excessive emancipation or total independence from the family would be disastrous for the child; actually the child is asking for discipline and controls, although outwardly he gives the impression of indifference and even outright disgust at times. Therefore the family circle must remain almost totally intact until the child has matured, or has passed the adolescent stage. Family strengths and ties receive their most serious test when the child passes into the adolescent phase.

> The stereotype conception of the parents of the adolescent is one of confused helplessness. To nurture the infant and the young child, they thought, was an arduous but clear-cut task. The adolescent does not make heavy demands for nurturance in the form of physical care, but the nature of the parental responsibilities—for nurturance and especially for control—becomes ambiguous and anxiety producing.[1]

This chapter was meant to emphasize two

1/Robert F. Winch, THE MODERN FAMILY, Holt, Rinehart and Winston, Inc., New York, Chicago, San Francisco, Toronto, London, 1963, (2nd ed.), p.522.

points: (1) the child and his gradual personality development; (2) the child and his relationship to society.

CHAPTER III

THE THEORETICAL BACKGROUND

In this specific study of malfunction of children — and most children brought to a child guidance clinic would be malfunctioning except those whose parents are over-conscientious or projecting, or in cases where the child is retarded — certain concepts and theories must be considered that bear on the general topic of emotional disturbance.

The first concept that must receive attention is 'psychopathology'; all children referred to a mental health clinic presumably have pathological behavior patterns. Technically this term means the systematic investigation of morbid mental states. Pathology comprises all that is diseased or goes against the norms of society: it is related to the social, biological, and pathological aspects of human life. Psychopathology refers to the psychological entity of the individual, but in the general sense it also covers

the social adjustment of the individual. As applied to children, psychopathology is generally a reflection on the environment in which the child lives. There are two factors which influence the child's emotional make up: his own inborn characteristics and the upbringing he receives. The former factor has less relationship with psychopathology because the individual has natural elements to enable him to develop harmoniously, except if he suffers from any organic damage.

Another influential factor in a child's life is the 'psychodynamics' or the activity of his psychic forces. The term comprises both normal and abnormal behavior. Psychodynamics are set in motion by the drives or motives of the individual; it is a system which involves the activity of psychological processes which are changing or causing changes in the individual. The individual's behavior is actually the outside sign of such psychological processes.

A third concept related to this study is

'psychogenetics'. Every individual has psychological or psychic characteristics which control his behavior; and psychogenetics refer to the origin and development of these characteristics.

'Psychology' is another concept which will be used in any study involving the human being as a whole. It is not a specific concept, and it is not referring to psychology as a science but as an influential or causative factor in the individual's behavior. As a science it involves the accurate categorizing of human motives in compartments for direct study; it is also used to give a clinical picture of the individual. As a concept it is not so exclusive and comprises all the emotional and intellectual activities of the individual.

A diagnostic classification is also necessary in a study such as this one. There is a definite need for it, especially as a working tool. The following is a classification which is mostly derived from Bakwin and Bakwin.[1] This classifi-

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1/Harry Bakwin & Ruth Morris Bakwin, CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN, W.B. Saunders Company, Philadelphia & London, 1953.

cation divides the child into three stages: infancy, childhood, and adolescence. In infancy there are three categories: (1) anaclitic depression and hospitalism which are caused by maternal deprivation; (2) feeding problems which consist of incorrect maternal handling; (3) toilet training caused by too early or inconsistent handling practices.

With the childhood years, the disturbances become more complex in both etiology and nature. These main groups of disturbances consist of: primary behavior disorder, neurosis, psychosis, and organic disturbances. The first of these disturbances is subdivided into three other specific pathologies: habit disorder, conduct disorder, and neurotic trait symptoms. The child suffering from a habit disorder may have any one or more of these characteristics: nail biting, enuresis, temper tantrums, thumb sucking, and masturbation. What seem to be the causes of these? — an overprotective mother, immature mother, forcing mother, inactive father, or interference from in-laws. The child

with conduct disorder generally shows inability to handle aggressiveness in his home, school, or in the community. This child may be living in a family of gross disintegration or in an area of sub-standard living accommodations; he may also be frail in super-ego development due to absence of loving and consistent mother-father figures. The child showing neurotic trait symptoms is characterized by shyness, tics, somnambulism, overactivity, general nervousness, night terrors, habit spasms, stammering, phobias, and somatization. These symptoms are more common in girls and may be caused by long exposure to a neurotic mother, a passive father, or over-conscientiousness on the part of the child.

Neurosis is the second main group of disturbances during the childhood stage. It is usually incorporated as part of the personality and includes obsessive neurosis, hysteria, and anxiety states.

Psychosis is not too common with children; such a child is indolent and confused, and the auti-

stic child may show symptoms of deafness. The child may be either manic-depressive, schizophrenic, or suffer from early infantile autism. With the organic disorders, the emotional disturbance is only secondary to recognized organic syndromes. Temper tantrums may sometime be the result of organic damage; also odd and apparently non-provoked abnormal behavior may be traced to organic defects.

The third stage in this classification is adolescence. The characteristics are as follows: (1) excessive adolescent rebellion, which is an exaggeration of 'normal adolescent' behavior; (2) juvenile delinquency, when the child is aggressive, destructive, and anti-social; (3) autistic trends, characterized by exaggeration of day dreaming but not of a schizophrenic nature; (4) schizophrenia; (5) hypochondriasis which may be the beginning of neurotic traits or a temporary phase of heightened self-awareness.

Society is concerned with giving the individual an opportunity to adjust and grow harmoniously.

Over the past two centuries the individual has been granted well deserved rights. The mentally ill is no longer cursed for his insanity, the delinquent and criminal receive counseling and therapy, the disabled and handicapped are rehabilitated. This has greatly enhanced the emotional stability of the individual.

Nevertheless, everything is not of an idealistic nature. Every factor directly or indirectly concerned with the living process is weak or inappropriate at times. The environment, both social and cultural, inhibits adequate functioning of individuals and of groups; the attitudes of some people in authority often run against the individual's spontaneous and healthy growth. These pathological reactions affect the individual's psychological growth and his actions, particularly during the formative years of the person.

This study supports the view that most children who are disturbed emotionally during their early years, become disturbed due to their parents'

or guardians' indolence or inaptitude at giving their offspring or proteges sound guidance and handling; and if parents or guardians show incompetence, it stems from the fact that they are malfunctioning at some level.

How many forms does emotional disturbance take? In one broad description, an emotionally disturbed child is one who suffers from a disorganized personality; in areas of behaving or reasoning or of underlying psychic forces, the child shows deviation from what is considered to be the normal limits of adjustment. The general symptoms of personality disorganization consist of 'acting-out' or 'acting-in' behavior, or a combination of both.

The dividing line between normal and abnormal personality is very thin, or actually nonexistent. The malfunctioning individual shows peculiarities that are present in every other individual to a lesser degree; situations may provoke pathological reactions in any so-called 'normal'

individual. Maladjustment may be considered as a failure to achieve a satisfactory compromise between giving in to powers too great to change, and modifying the environment in order to make it acceptable to the individual's patterns of thoughts and actions. Thus the psychogenic causation of malfunction lies in the individual's personality make-up, because the personality is the individual's way of coping with the environment; it is the habitual patterns of behavior of the individual. "External circumstances which frustrate or fail to satisfy the child's basic needs often produce pathogenic disturbances".[1] When referring to the 'child's basic needs', the author also means needs which are of a psychological nature.

Thus, throughout any stage of the child's formative years, he may develop disorders in his personality. As has been shown in the classification, the stages are quite clearly defined, and

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1/Hyman S. Lippman, TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT, McGraw-Hill Book Company, Inc., New York, Toronto, London, 1962, (2nd ed.), p.3.

particular emotional problems may occur at a certain age that will not happen at another age. For instance, feeding problems occur during infancy, while neurosis occurs during a later stage of life.

The parent-child relationship is of the utmost importance in the life of the young individual. What can the child achieve if his relationship to his parents is unhealthy? Not much, unless the child has extra-familial ties.

> In most cases the child's fixation results from the adult's inordinate need to keep the child dependent upon him for his own emotional outlets.... An unwanted child who lives with his rejecting parents continuously feels unloved. A parent's emotional rejection always creates feelings of unhappiness and emptiness in a child and often produces depression.1/

and the author continues thus:

> In most cases rejection is only one part of an ambivalent attitude which the parents have toward their child. An ambivalent parent accepts and rejects his child at the same time because he both loves and hates him.2/

1/<u>Ibid</u>., p.135 & p.136.

2/<u>Ibid</u>., p.136.

formative years. One of the aspects of the identification process is that it is never ending: even the elderly person identifies with somebody. The child receives a great deal of security through identification, and once security is achieved, it gives the child a lot of strength. However due to the changing characteristics of the identified person, and mostly because of the change in the child himself as he matures, the security derived from the identification process is only proportionate to the flexability of the child to adjust to changing emotional and communication patterns. Identification is basically a one-to-one relationship.

The identification process takes a very irregular course. Two significant milestones occur: with the Oedipus or Electra phases after which the child settles down somewhat; and during the adolescent period when all acquired values are re-appraised by the child.

When the child identifies with his parent or parents, he reaches for almost anything that is

offered, in his desire to learn and grow. Therefore if the individual he identifies with shows marked dysfunctioning, the child will acquire gross malfunctioning directly or through the process of psychological osmosis. Whichever way the individual performs in life, it will be directly or indirectly as a result of his parents' behavior and personalities. How else can he learn especially when the only environment he knows is his family.

The parent-child relationship is the main concern of this study.

> The relationship between a mother and her child must not be regarded as something static and crystallized, but as a dynamic reciprocal living process which is altering, and developing in a time continuum. The emotional attitude of the mother may be inimical to the child's interests if she is unable to perceive the reality of the child as a separate individual, and if she cannot react adequately to his needs for love, protection, control, stimulation, freedom to develop, etc. The perception of the child as a separate individual, and the desire to satisfy his needs as she perceives them, may be interfered with by various factors operating within the mother or impinging upon her from her own relevant emotional environ-

ment.[1]

This author stresses the obnoxious influence of the mother's emotional disturbance on the growth of the child; this may be said of the father also, to a lesser degree in early childhood, but with increasing effect on the child's personality as he grows.

Neurosis seems to be the most easily absorbed pathological trait by the child from either parent.

> These ((neurotic)) manifestations may result from the parents' insistence that the child behave in an oversocialized manner. On the other hand, they may result from repression in the child due to neurotic conflicts in the parents who cannot tolerate any other behavior.[2]
>
> The superego of the neurotic child tends to be rigid and severe.[3]
>
> The essence of neurotic conflict is a weakened ego.[4]

1/Gerald Caplan, (ed.), EMOTIONAL PROBLEMS OF EARLY CHILDHOOD, Basic Books, Inc., New York, 1955, p.155.

2/Lippman, op cit., p.91.

3/Lippman, op cit., p.91.

4/Lippman, op cit., p.92.

The first quotation supports the fact that the causative factors in children's neurosis lie in the parent's behavior and responses. The other two quotations also support the same principle: the ego of the individual develops during the ages of from two to four approximately, and the super-ego is superimposed on the ego from the fourth year of life generally. Therefore neurosis in the child is brought about almost exclusively by the parents who are the ever present adults catering to his needs. From this, it may be concluded that neurosis fosters neurosis in an almost direct pattern of succession.

Other maladjustments in childhood are also related to parental maladjustment in their life patterns, but not to the same extent as neurosis, or so it would seem.

It may be important at this point to dwell briefly on some binding and conclusive designs of certain authorities in this field of study.

Ackerman and Behrens[1] in a study on family diagnosis claim that child behavior during the first three years is more consistently influenced by maternal handling than by other environmental factors. In the same study they came to the conclusion that poor handling in any given area is likely to be associated with 'problem' behavior in the child in that area, but that this does not generalize in the child to other areas. It is also apparent that the type of maternal derivation varies in effect in the different areas of child behavior; e.g. overpermissiveness produces problems in sleep; rigidity, in feeding and socialization. They also concluded that as the original psychic unity with the mother lessens, omnipotent behavior gives way to an increasing measure of real control, exploration, and progressive testing; impairment of these processes interferes with learning. Ackerman and Behrens also

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1/Nathan W. Ackerman & Marjorie L. Behrens, "A Study of Family Diagnosis, AMERICAN JOURNAL OF ORTHOPSYCHIATRY, v XXV, April 1955, p.253.

> ment on those aspects of reality which heretofore have been the sole priority of an adult world of which he was not a part.[1]

Another aspect of the parent-child relationship is stressed by Blau and Hulse:

> The etiology of childhood anxiety neurosis with behavior disorder is, in our experience, also found to be related to a rejecting hostile attitude in the parental atmosphere.... The rejecting parental attitude is often unconscious and covered by reaction formations which take the form of over-protection and over-concern.... The fact is that these mothers usually suffer from marked personality disturbances with psychoneurotic or psychotic characters and the child behavior disturbance is generally intimately involved with their own conscious feelings.[2]

Jules Henry set out to prove the following three propositions; however he could not prove them except by manipulations of statistics; but the content of these propositions is nonetheless relevant:

> 1st proposition:- individuals learn relatively rigid patterns of interaction, which they tend to project upon the world in such a way as to expect reciprocal patterns from others.

1/*Ibid*., p.269.

2/Abram Blau & Wilfred C. Hulse, "Anxiety ("Actual") Neuroses as a cause of Behavior Disorders in Children", AMERICAN JOURNAL OF ORTHOPSYCHIATRY, v XXVI, January 1956, p.111.

> 2nd proposition:- from the standpoint of intrafamilial interaction, neurosis may be considered a rigid pattern of pathogenic quality. 3rd proposition:- family interactional patterns may be described with a relative precision that will enable us to state the general psychological characteristics of families.1/

In this same article J. Henry made the assumptions that interactional analysis makes it possible to state, with relative precision, how family traits are scattered, and why scattering occurs; thus each member of the family may embody the pathology in a different way and in different intensities, while some may not have it at all. This would seem to indicate, according to J. Henry, that some children can be well adjusted individuals in a disorganized family, but this could be due to the fact that the interaction between the parents and these children was on a non-pathological level.

Melitta Sperling mentions some previous

1/Jules Henry, "Family Structure and the Transmission of Neurotic Behavior, AMERICAN JOURNAL OF ORTHOPSYCHIATRY, v XXI, Oct. 1951, p.800.

demonstrative studies which are quite pertinent.[1/] (1) the existence of psychological rapport between child and mother; (2) difficulties in analytic treatment of the child caused by the unconscious resistances of the mother stemming from her relationship with the child; (3) the significance of the neurotic milieu for the child; (4) certain emotions and affects of the mother seem to transmit themselves to the infant, causing clinical symptoms. In another part of the same article, the author notes:

> In cases where the mother, because of her own neurosis or psychosis, carries over to the child, by projection or identification, her unresolved infantile conflicts, this inability of the mother to separate herself from the child makes for a continuation of a relationship which we assume to exist in infancy. In such a relationship, which would seem to be the model for hypnotic dependence, the child carries out the wishes, that is, commands, of the mother unconsciously.[2/]

1/Melitta Sperling, "The Neurotic Child and his Mother: a Psychoanalytic Study", AMERICAN JOURNAL OF ORTHOPSYCHIATRY, v XXI, April 1951, p. 351.

2/*Ibid*., p.351.

But Melitta Sperling points out the following limitations which may, at least temporarily, baffle any researcher:

> From psychoanalysis of adults, we can reconstruct this psychological situation of the mother and child in retrospect only, and only from the standpoint of the patient's responses, colored by his distorted psychic reality. From psychoanalysis of children, we know that the child's symptoms can be fully understood only within the frame of the child's environment and particularly the relationship with his mother.[1]

Here is the conclusion of this chapter: parent-child relationship is so basic in the life of the child, that personality pathology or social pathology of the parent is reflected in the formation of the child's personality.

1/*Ibid.*, p.351.

CHAPTER IV

STUDY DESIGN AND FINDINGS

This research project consisted of the studying of 221 files of children who were psychiatrically or psychologically assessed by The Halifax Mental Health Clinic for Children. Out of this number eight files were void, bringing the total down to 213. The files used were those opened during the calendar year 1960.

Sixteen people, including the researcher, collected the necessary data from these files and transferred it on some previously drawn up schedules. These schedules were set up so that the necessary information for the sixteen researchers could be gathered in one process. No interviewing of the 1960 clients or of anybody concerned with these cases was carried out. Every bit of information was gathered from the files. The cases studied were of the general population; files were not picked up at random.

47 cases were classified as 'Retarded Cases'

by The Halifax Mental Clinic for Children authorities, and were not used by the researcher. Five other children whose I.Q.'s were 70 or below were also disregarded. This brought the total number of cases to 161. 25 other cases were ignored because of the lack of necessary information or because the children suffered from no apparent emotional disturbance. 8 more clients were disregarded due to the fact that the parents' emotional and psychological state was not recorded: this information was needed by the researcher in order to assess the degree of relationship between the children and their parents. The total number of cases was subsequently dropped to 119 after the researcher had screened out 9 more: these were found to be of obvious or apparent organic brain damage. The relationship between these children and their parents or guardians was primarily not of an emotional or psychological correlation, and the researcher could not use these cases.

The diagnosis of children, as mentioned

previously, was not spelled out in all cases. Therefore the researcher classified these children according to their marked symptoms: an accurate diagnosis was not possible, and due to the shortage of time allowed on presenting this research project, an objective comparison and discussion of diagnosis with one or more researchers was not possible.

Of the 119 disturbed children, 51 were assessed as neurotic and 45 as conduct disorder; the other 23 were labeled 'other disorders' and included 5 cases of schizophrenia, 5 of immaturity, 6 of personality disorder, 4 of habit disorder, 2 of primary behavior disorder, and 1 of emotional neglect.

The children in this study were divided into two groups according to their parents' personality functioning. 76 parents were considered to be disturbed by the researcher and the remaining 43 were relatively normal. The first group was subdivided into three groups: (1) Those with per-

sonality stresses of psychotic or near psychotic nature. This included schizophrenia, depressions, paranoid delusions, neurosis, personality disorders, phobias, somatic complaints, symbiotic interdependences of child and parent, insecurity, anxiety, compulsiveness, and obsessiveness. (2) Those parents with defective disciplining patterns: inconsistence, harshness, or complete lack of disciplinary measures, and other gross disciplinary defects such as quarrelling over discipline. (3) Parents characterized by multifaceted pathological interaction between mother, father and child; also acute behavioral dysfunction. This included gross marital discord, severe lack of love for the child, rejecting or domineering attitudes, aggressivity or irresponsibility, overprotection, immaturity or retardation, role inversion; behavioral dysfunction included lack of sexual adjustment, gross moral deviation such as prostitution, and alcoholic addiction. The researcher found 31 parents in the first group, 24 in the defective discipline group, and 21

in the third group.

To analyze the value of data that is not quantitative, a certain process of statistical form must be considered. A null hypothesis has to be disproved if the theory is to be significant; the null hypothesis is like a roundabout way of saying what can be said simply and directly.

The chi-square is used in this project to disprove or prove the null hypothesis. The chi-square process actually means that what has been found happened or did not happen by chance alone. The following is what was found in this study:

Class	(f) Observed Frequency	(f) Expected Frequency	(f-f')	$(f-f')^2$	$\frac{(f-f')^2}{f'}$
C.D.	.342	.442	-.100	.0100	.023
N.	.447	.395	.052	.0027	.007
Others	.211	.163	.048	.0023	.014
Total					.044

The observed frequency was the 76 parents considered to be malfunctioning, while the expected frequency consisted of the 43 parents considered normal. 26 (or .342) parents in the frequency column had children diagnosed as conduct disorder; 34

(or .447) had neurotic children; while 16 (or .211) parents had children with 'other disorders'. In the expected frequency column 19 (or .442) parents had children with conduct disorders; 17 (or .395) had neurotic children; and 7 (or .163) had children who suffered from 'other disorders'. The chi-square total of this was .044, and with two degrees of freedom, was termed insignificant.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

There is no significant relationship between the malfunction of parents and the malfunction of their children assessed at The Halifax Mental Health Clinic for Children during the calendar year 1960; the null hypothesis has not been disproved.

Two main reasons would probably account for this. It may either be in the study design of this project, or in the theory.

The theory was perhaps presented in too abstract a way by the researcher. The symptomatology of the parents was difficult to measure: the dividing line between normal behavior and pathology could be moved quite freely inside a fairly wide range.

The study design was somewhat inadequate. The researcher was looking for gross pathology, and a lot of damaging patterns of behavior in the parents, may have been mistaken as minor and insigni-

ficant.

In many cases, if the parents had been seen for a longer period of time, some pathology might have been found which was not evident otherwise.

If such a project is undertaken again, the next researcher should prepare his data well in advance. The files should be complete in the diagnosis of the children and the symptomatology of their parents or guardians. The study design should be more pertinent and more carefully planned, and the theory presented in more concrete and measurable terms.

Some information on past behavior and living experiences of the parents would be a necessity also, because of what Gordon Hamilton says:

> In child guidance, since the parents are currently acting out and unconsciously, through their own children, reliving former emotional experiences, the past is active in the immediate present in a special way.[1]

1/Gordon Hamilton, PSYCHOTHERAPY IN CHILD GUIDANCE, Columbia University Press, New York, 1947, p.314.

APPENDIX

MARITIME SCHOOL OF SOCIAL WORK

RESEARCH PROJECT, 1963-1964

Schedule for Reading Mental Health Clinic Records

Schedule No ________

Read by ____________ initials - date   Edited by ____________ initials - date   Coded by ____________ initials - date

I. ADMINISTRATIVE INFORMATION

1. MHC case number ____________
2. Month & year of referral ____________
3. Mo & yr of workup ____________
4. Mo & yr treatment began ____________
5. Mo & yr treatment ended ________
6. Sex of patient: male / female
7. Mo & yr of patient's birth ____________
8. Status of case on October 1, 1963:

(___) referred but family not yet seen

(___) referred but service rejected

(___) workup indicated no real problem

(___) workup indicated untreatable problem (specify):

(___) workup indicated problem for which no resource available

(___) workup indicated problem for resource other than MHC (specify):

(___) MHC treatment offered but refused

(___) MHC treatment offered, on waiting list

(___) family withdrew while on waiting list for reality reasons

(___) family withdrew while on waiting list for psychological reasons

(___) family in treatment

(___) family withdrew while in treatment for reality reasons

(___) family withdrew while in treatment for psychological reasons

(___) treatment terminated as completed

(___) other status (specify):

mhc--2

II. REFERRAL Schedule No ____________

I. Was family self-referred (___) from own knowledge of MHC

(___) at suggestion of relative, friend, neighbour

or

was family referred in the line of duty by

(___) private doctor (___) public health clinic or service, hospital, etc.

(___) teacher, etc. (___) minister, etc.

(___) police court, etc. (___) social or recreational agency, etc.

(___) other (specify):

or was source of referral not recorded (___)

2. Source reference number ____________ .

3. What was source's initial statement of reason for referring, and what symptomatic behavior triggered action by source:

(___) check here and continue on back of sheet if necessary

III. FAMILY CONSTELLATION   Schedule No ________

(___) Check here if this sheet refers to other than the biological family of patient, and explain:

1. Father: birthplace: mo & yr born:
ethnic origin: religion:

2. Mother: birthplace: mo & yr born:
ethnic origin: religion:

Children (list with oldest first, include patient and identify with "P" in left-hand margin; identify others in treatment with "T". IF ADOPTED, GIVE DATE CHILD JOINED FAMILY AFTER DATE OF BIRTH)

3. Ma/Fe birthplace: mo & yr born:

4. Ma/Fe birthplace: mo & yr born:

5. Ma/Fe birthplace: mo & yr born:

6. Ma/Fe birthplace: mo & yr born:

7. Ma/Fe birthplace: mo & yr born:

8. Ma/Fe birthplace: mo & yr born:

9. Ma/Fe birthplace: mo & yr born:

Other significant persons (specify role or relation with respect to patient, but not name)

a. ________ birthplace: mo & yr born:
ethnic origin: religion:

b. ________ birthplace: mo & yr born:
ethnic origin: religion:

c. ________ birthplace: mo & yr born:
ethnic origin: religion:

d. ________ birthplace: mo & yr born:
ethnic origin: religion:

e. ________ birthplace: mo & yr born:
ethnic origin: religion:

(___) Check here if religion of any child is other than that shown for father and explain below, identifying child by number from this sheet

(___) Check here and continue on back of sheet if necessary

III. FAMILY CONSTELLATION (Ctd) Schedule No ___________

Fill in dates of any change of status for each family member, using same number or letter to identify individuals as used on page 3.

	Single	Married	Cohabit.	Deserted	Sep'ted	Div'ced	Widowed
1. Father	______	______	______	______	______	______	______
2. Mother	______	______	______	______	______	______	______

Children (list with oldest first, include patient and identify with "P" in left-hand margin; identify others in treatment with "T")

3.	______	______	______	______	______	______	______
4.	______	______	______	______	______	______	______
5.	______	______	______	______	______	______	______
6.	______	______	______	______	______	______	______
7.	______	______	______	______	______	______	______
8.	______	______	______	______	______	______	______
9.	______	______	______	______	______	______	______

Other significant persons (specify role or relation with respect to patient, but not name)

a. ____________	______	______	______	______	______	______	______
b. ____________	______	______	______	______	______	______	______
c. ____________	______	______	______	______	______	______	______
d. ____________	______	______	______	______	______	______	______
e. ____________	______	______	______	______	______	______	______

(___) Check here if marital history of family cannot be shown clearly above, and explain below:

(___) Check here and continue on back of sheet if necessary

IV. LIVING QUARTERS

Schedule No ________

Fill out one sheet for each home that family has had. If more than three during the patient's childhood, report the three most recent, check here (___) and summarize on back of the last sheet the similarities and differences of earlier living quarters to those reported.

1. Address:

2. Mo & yr in: 3. Mo & yr out:

(___) if this is an institution check here and omit remainder of sheet

4. (___) single (___) duplex (___) apartment (___) tenement (___) lodgings

5a. Number of rooms: 5b. Number of occupants:

6. Type of house:
(___) Excellent
(___) Very good
(___) Good
(___) Average
(___) Fair
(___) Poor
(___) Very poor
(___) Not recorded

7. (___) Owned? what value?
(___) rented; what rent?
(___) free; from whom? why?

8. Housekeeping standards (note informant):

(___) Check here and continue on back of sheet if necessary

9. Neighborhood attitudes to family:

(___) Check here and continue on back of sheet if necessary

V. FAMILY OCCUPATION AND INCOME

This sheet refers to (___) breadwinner
(___) patient
(___) other member of family (specify above)

1. Present or most recent employment, as recorded:

2. (___) Check here if employment above is typical or appropriate: otherwise note below what is typical and why above is not:

(___) Check here and continue on back of sheet if necessary

3. If not working but recently employed, check reason for leaving employment, and note significant information from record:

(___) termination (___) performance (___) behavior (___) illness
(___) voluntary (___) not recorded

4. Source of income: (___) Inherited wealth (___) Wages
(___) Earned wealth (___) Private relief
(___) Profits & fees (___) Public relief & non-respectable income
(___) Not recorded (___) Salary

5. Income: (___) Not recorded; $ _______ per day/week/month/year.

6. Does record indicate that family considered income to be

(___) most adequate (___) just adequate (___) almost adequate

(___) insufficient

Explain:

(___) Check here and continue on back of sheet if necessary

VI. EDUCATION

Schedule No ___________

Fill in all obtainable information for each family member, using same number or letter to identify individuals as used on page 3

	STILL IN SCHOOL		LEFT SCHOOL		NOT RECORDED
	Age/date	Grade	Last grade completed	Age in last grade completed	
1. Father	____	____	____	____	____
2. Mother	____	____	____	____	____

Children (list with oldest first, include patient and identify with "P" in left-hand margin; identify others in treatment with "T"

	Age/date	Grade	Last grade completed	Age in last grade completed	NOT RECORDED
3.	____	____	____	____	____
4.	____	____	____	____	____
5.	____	____	____	____	____
6.	____	____	____	____	____
7.	____	____	____	____	____
8.	____	____	____	____	____
9.	____	____	____	____	____

Other significant persons (specify role or relation with respect to patient, but not name)

	Age/date	Grade	Last grade completed	Age in last grade completed	NOT RECORDED
a. ________	____	____	____	____	____
b. ________	____	____	____	____	____
c. ________	____	____	____	____	____
d. ________	____	____	____	____	____
e. ________	____	____	____	____	____

(___) Check here if record gives no significant information on attitudes of family members other than patient to school; otherwise note below:

(___) Check here and continue on back of sheet if necessary

VI. EDUCATION (Ctd)

Schedule No ____________

2. (___) Check here if record indicates that school performance was not significantly related to patient's difficulties; otherwise note below, especially with regard to school standing, changes of school, grades repeated, special classes, etc.

(___) Check here and continue on back of sheet if necessary

3. (___) Check here if record indicates that school adjustment was not significantly related to patient's difficulties; otherwise note below, especially with regard to truancy, expulsion, attitudes to school, attitudes of school personnel to patient, attitudes of peers to patient, etc.

(___) Check here and continue on back of sheet if necessary

VI. EDUCATION (Ctd) Schedule No ____________

4. (___) Check here if patient is still in school; otherwise check reason for leaving below and explain:

(___) financial
(___) health
(___) intellectual
(___) behavior
(___) own attitudes
(___) family attitudes
(___) other (specify):

(___) Check here and continue on back of sheet if necessary

5. (___) Check here if record gives no information on IQ or other psychological testing under school auspices. Otherwise report in Section VII.

6. Patient's school history:

Age/date began	Grade began	School	Place	Age/date left

(___) Check here and continue on back of sheet if necessary

VII. HEALTH AND WELFARE Schedule No ____________

NOTE: This section does not relate to referral to the Mental Health Clinic of Halifax, but to other community agencies and services only.

(___) Check here if record indicates no significant referrals of patient or family to other community agencies or services; otherwise fill in one sheet for each significant referral:

1. Agency or service:

2. Mo. & yr. referred: 3. Mo. & yr. contact ended:

4. Service referred for or offered:

(___) Psychiatry (___) Psychology (___) Casework (___) Medical

(___) Other (specify):

5. Person referred:

6. Presenting problem:

(___) FINANCIAL: employment placement, vocational guidance, vocational training; social insurance claim; social assistance request; shelter care; service for transients; etc.

(___) EMOTIONAL: psychiatric; casework; counselling or guidance; delinquency or correctional

(___) CHILD WELFARE: emergency homemaker, day care, foster care, adoption; neglect and protection, etc.

(___) HEALTH: hospital, nursing or convalescent home, out-patient clinic; home nursing; specific health problem service

(___) RECREATION

(___) OTHER (Specify):

7. Outcome, for person referred and for others affected:

(___) Check here and continue on back of sheet if necessary

8. If record shows a professional assessment of patient or parents, give detail below (for WAIS & WISC, give Performance, Verbal and Full Scale scores, if given):

(___) Check here and continue on back of sheet if necessary

VIII. FAMILY DYNAMICS

Schedule No __________

1. (___) Check here if record gives no significant information on family functioning; otherwise note below, especially as regards housekeeping and living arrangements, eating and food preparation, money handling, discipline, recreation, family routines and rituals, and family values:

(___) Check here and continue on back of sheet if necessary

2. (___) Check here if record gives no significant information on the pattern of relationships within the family; otherwise note below, especially as regards positive, neutral or negative relations of patient to parents, siblings or other significant persons, and as regards parental conflict:

(___) Check here and continue on back of sheet if necessary

VIII. FAMILY DYNAMICS (Ctd) Schedule No ___________.

3. (___) Check here if record gives no significant information on family dominance patterns; otherwise note below, especially as regards stable or fluctuant nature and whether members accept or rebel against the pattern:

(___) Check here and continue on back of sheet if necessary

4. (___) Check here if record gives no significant information on family patterns of reacting to environmental or internal stress; otherwise note below, especially as regards nature and degree of stress, reaction pattern, effectiveness of reaction pattern, integrative or disintegrative effect of experiences:

(___) Check here and continue on back of sheet if necessary

4a.(___) Check here if record gives no significant information on family attitudes towards the community; otherwise note below, especially as regards family competitiveness with respect to others, and whether the family rebels or ignores the values of others about them:

(___) Check here and continue on back of sheet if necessary

VIII. FAMILY DYNAMICS (Ctd) Schedule No ____________

5. (___) Check here if record gives no significant information on family's handling of social roles; otherwise note below, especially as regards whether roles are accepted or rejected; whether complementarity of roles exists or not, whether there is disparity between conscious and unconscious roles or not, whether roles are culturally appropriate or not, whether members deviate from characteristic handling of roles or not:

(___) Check here and continue on back of sheet if necessary

6. (___) Check here if record gives no significant information on family's goals; otherwise note below, especially as regards existence of common goals if any (particularly educational or vocational), whether goals are appropriate or not, whether there has been success in achieving family goals, whether achieving family goals has called for individual sacrifices or not:

(___) Check here and continue on back of sheet if necessary.

7. (___) Check here if record gives no significant information on the nature and degree of individual satisfactions derived from family participation; otherwise note below:

(___) Check here and continue on back of sheet if necessary

mhe--15

IX. PERSONALITY   Schedule No ________

1. (___) Check here if record gives no significant information on stressful experiences during developmental years; otherwise note below, and show nature and degree of stress, age or date, and effect on personality; in particular note any parental absences and their duration:

(___) Check here and continue on back of sheet if necessary

2. (___) Check here if record gives no significant information on identifications made during developmental years; otherwise note below, and show with whom identification was made, type of model offered, and effect on personality formation:

(___)Check here and continue on back of sheet if necessary

3. (___) Check here if record gives no significant information on basic attitudes; otherwise note below, especially as regards sense of self-worth, sense of trust in others, capacity for initiative, capacity for love, attitudes to authority and limits, attitudes to own and other sex roles, and capacity for socially acceptable functioning:

(   ) Check here and continue on back of sheet if necessary

IX. PERSONALITY (Ctd) Schedule No_______________

4. (___) Check here if record gives no significant information on adjustive capacities; otherwise note below and also check the list shown:

(___) intelligence
(___) emotional sensitivity
  to self
(___) to others
(___) capacity for emotional relationships
(___) plasticity in traits and defences
(___) assertiveness
(___) self-esteem
(___) conscience
(___) tolerance for reasonable stress or anxiety
(___) ability to gratify vital biological and social needs in conformity with mores of significant groups

(___) Check here and continue on back of sheet if necessary

mhc--17

IX. PERSONALITY (Ctd) Schedule No ______________

5. (___) Check here if record gives no information on defensive mechanisms; otherwise note below, and also check the list shown:

Conscious effort

(___) withdrawal, actual
(___) bodily satisfactions
(___) distractive activity
(___) day-dreaming
(___) suppression
(___) rationalization
(___) philosophizing
(___) "self-control"
(___) acting out
(___) "thinking through"
(___) alcoholic indulgence
(___) use of drugs

Repressive defences

(___) reaction formations
(___) accentuated intellectual controls
(___) blunted mentation
(___) disturbed consciousness
(___) disturbed memory
(___) emotional inhibitions
(___) sensory disorders
(___) motor paralyses
(___) visceral inhibitions
(___) displacement and phobic avoidance
(___) undoing and isolation

Personality defences

(___) over-dependency
(___) submissiveness
(___) expiatory patterns
(___) dominating patterns
(___) aggressive patterns
(___) withdrawal, emotional
(___) narcissistic patterns
(___) compulsion to power

Regressive defences

(___) helpless dependency
(___) withdrawal from reality
(___) depressions
(___) excited acting-out

(___) Check here and continue on back of sheet if necessary

mhc—18

IX. PERSONALITY (Ctd) Schedule No ______________

6. (___) Check here if record gives no significant information on symptons of personality malfunctioning in childhood; otherwise note below and also check the list shown:

Habit disorders

(___) vomiting
(___) crying
(___) picking
(___) scratching
(___) masturbation
(___) enuresis
(___) rocking
(___) head banging
(___) nail chewing

Neurotic traits

(___) jealousy
(___) shyness
(___) nightmares
(___) sleepwalking
(___) stuttering
(___) phobias
(___) withdrawal
(___) general "nervousness"

Conduct disorders

(___) defiance
(___) tantrums
(___) destructiveness
(___) cruelty
(___) overactivity
(___) secretiveness
(___) lying
(___) stealing
(___) sex exhibitionism
(___) delinquencies

Psychophysio disorders

(___) anorexia nervosa
(___) constipation
(___) chronic diarrhoea
(___) fainting
(___) migraines
(___) eczema
(___) asthma

(___) Check here and continue on back of sheet if necessary

IX. PERSONALITY (Ctd) Schedule No ________

7. (___) Check here if record gives no significant information on diagnosed psychiatric disorders; otherwise note below, indicating date or age when diagnosis was made and source of diagnosis.

SOURCE: ______________________________

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IX. PERSONALITY (Ctd) Schedule No ______________

8. (___) Check here if record gives no significant information on the patient's acceptance or rejection of family, religious or cultural values; otherwise note below:

(___) Check here and continue on back of sheet if necessary

9. (___) Check here if record gives no significant information on the acceptance or rejection of the family by neighbors, peer or reference groups; otherwise note below:

(___) Check here and continue on back of sheet if necessary

X. SPECIFIC AREAS OF VALUE OF RECORD

Schedule No ____________

Check here as appropriate if this record has particularly significant or complete material with regard to:

(___) Emotional effect on patients of preceding siblings (boys: AM, girls: EL)

(___) Parent personality patterns or family dynamics (CL, AL)

(___) Difficulties of intellectual functioning of child (NS)

(___) Parental incompatibility or rejection of the child (RR)

(___) Relationship between socio-economic level and aggression (JB, WG, CF, DR, BC)

(___) Families poorly integrated within themselves or to their society (VH)

(___) Parental absences or separations (NB)

(___) Referrals from the community (NT, NC)

(___) School difficulties (NN)

If this record appears to you to be well suited as an example of some other aspect of referral, pathology, treatment or other aspect of service, note briefly below

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BIBLIOGRAPHY

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